



East London and the City



Tower Hamlets annual public health report 2010



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We are delighted to present the Annual Public Health Report for 2010.

This report was initially developed when Dr Ian Basnett was the Joint Director for Public Health for Tower Hamlets. Ian has now become Director of Public Health for East London and the City Alliance. We would like to thank him for his leadership over the past three years. He leaves a directorate with a strong reputation and record of achievement.

The report provides an update on trends in health and wellbeing in Tower Hamlets, sets out the findings of our local healthy lifestyles survey and focuses on cancer, a priority area in view of particularly poor local outcomes.

The findings highlight that the health of people in Tower Hamlets continues to improve in line with national trends. However, headline indicators of health such as life expectancy remain significantly lower than England and this is strongly associated with the levels of socioeconomic deprivation in the borough. The healthy lifestyles survey demonstrates at local level how this is linked to lower prevalence of healthy behaviours in the population.

Cancer death rates in Tower Hamlets have consistently been amongst the worst in the country. In some instances, this is because of higher incidence, for example higher rates of lung cancer linked to high levels of smoking in the population. However, in other cases it is due to poorer survival. For example, survival from breast cancer is amongst the lowest in the country, although incidence is comparable to elsewhere. This highlights the importance of local plans to promote early diagnosis through screening and early awareness of symptoms.

This is a time of major changes that have the potential to have significant impacts on the health of people in Tower Hamlets. The economic climate and public spending cuts affect the wider determinants of health such as employment, income, poverty, housing and education which powerfully influence both health and the need for health and social care services.

In the face of significant restructures within the NHS, the public health system and the local authority we will need to work harder than ever to ensure that we use our resources as effectively as possible to improve health and wellbeing in Tower Hamlets.



Somen Banerjee

Joint co-directors of public health NHS Tower Hamlets and London Borough of Tower Hamlets

Esther Trenchard-Mabere

Tower Hamlets: A summary of health and wellbeing

Population

The Tower Hamlets population in 2010 is estimated to be 242,000. It is a population characterised by diversity (50% of the population are non white and 34% Bangladeshi), mobility (19% move in or out of the borough per year), high growth (although this uneven across the borough) and a significantly higher proportion of young people than elsewhere (37% are aged 25-39 compared to 27% across London). Growth is predicted through a local planning model that links population growth with residential development and this suggests that the population will reach 264,000 by 2016.

Health headlines

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Male life expectancy is 75.3 years compared to 77.82 nationally and female life expectancy is 80.4 compare to 81.95 (2006–8). The Borough has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). Trends indicate year on year improvement but with limited reduction in the gap.

Socioeconomic determinants of health

The most important factor accounting for health inequalities between Tower Hamlets and elsewhere is socioeconomic deprivation. The borough is ranked the third most deprived nationally. 78.5% of Tower Hamlets residents live in the 20% most deprived areas in England compared to around 26% of London residents. This is reflected in statistics indicating the highest levels of child poverty in the country, amongst the highest unemployment rates in London, a higher proportion of people with no qualifications, lower educational attainment compared to the rest of the country (but improving), higher levels of overcrowding and significant levels of housing classified as 'non decent' (in 2008/09)

56% of council housing fell below the decent homes standard compared to 25% in London).

Early years

The birth rate in Tower Hamlets is similar to the London average. 45% of births are to Bangladesh mothers. Although a higher proportion of newborns have lower birth weight (<2500g), infant mortality rates are not significantly different to London. Breast feeding initiation rates are higher than London. Tooth decay rates in five year olds have been improving but remain higher than London. Childhood obesity in 4–5 year olds is the 5th highest in London.

Children and young people

60% of under 19s are Bangladeshi. 55% of Tower Hamlets under 16s are classified as living in poverty (the highest levels of child poverty in the country). 1 in 5 children under 15 have tried a cigarette (similar to national averages) and 4 out 10 retailers are estimated to be selling cigarettes to under 18s. Tower Hamlets has the 2nd highest prevalence of obesity in year 6 in the country. 3 in 10 children have ever had an alcoholic drink compared to 7 in 10 nationally (reflecting the large Muslim community in the borough). Teenage pregnancy rates are lower than England and London averages following a recent downward trend although recent data indicates that rates are expected to increase for 2009. Childhood immunisation uptake is higher than London and MMR uptake at 24 months and 5 years has increased significantly over the past year (2010 data indicates over 92% uptake of second MMR). The number of children on the Child Protection Register has increased sharply over recent years. This primarily reflects



increases in ascertainment. Prevalence of mental health disorders in children is similar to national averages (around 1 in 10).

Staying healthy and health protection

27% of adults in Tower Hamlets smoke compared to 21% nationally with particularly high smoking prevalence in Bangladeshi males. 9 out of 10 adults eat less than five portions of fruit and vegetables a day, compared to 7 out of 10 nationally. A lower proportion of adults participate in sport and active recreation (15.5% compared to 21.2% nationally). 1 in 2 adults have not had an alcoholic drink in the past year but in the White population, 4 in 10 are classified as harmful drinkers compared to 2 in 10 nationally. Incidence of sexually transmitted infections (STIs) has increased significantly in the past few years. Tower Hamlets has the 8th highest rates of STIs per 100 000 population in the country (50% higher than the London rate). Prevalence rates of HIV have increased by 34% since 2005. 23% of HIV infections were diagnosed late in 2009 compared to 31% in London. Prevalence rates for tuberculosis have been rising slowly over the

past few years and reached 65.3 per 100 000 population in 2009, significantly higher than the London average of 45.1. Seasonal flu immunisation uptake is adequate in over 65s (76%) but lower in under 65s with long term conditions (55%) although this is above the national average (52%).

Long term conditions

Tower Hamlets has the highest or second highest mortality rates in London for the major long term conditions: coronary heart disease (CHD), stroke and chronic respiratory disease (COPD). Diabetes prevalence is higher than London and this is particularly linked with the high proportions of Bangladeshis in the population. Analysis of observed prevalence against expected for long term conditions indicates levels of under-diagnosis for most conditions but particularly hypertension, CHD, chronic kidney disease and COPD. In primary care, quality and outcome indicators are generally relatively good compared to London. Management of blood pressure and cholesterol in CHD and diabetic patients is generally well above the London average. Conversely, HbA1C, a measure of diabetes control, has been in the bottom guadrant in London and for this reason, diabetes was the first priority for the primary care packages introduced in 09/10. Despite generally good outcomes overall there remain significant variations between GP practices and this has been a major driver to standardise care through the primary care investment programme. Secondary care admission rates (age standardised) for CHD, stroke, heart failure and COPD are the highest in London.

Cancer

Tower Hamlets has the highest cancer mortality in London. This is driven to a significant extent by high incidence and mortality from lung cancer and reflects the high prevalence of smoking in the Borough. However, one year survival from cancer is in the bottom 10% nationally and this is particularly poor for breast, colorectal and prostate cancer. Cancer screening uptake is lower than national averages (breast, cervical and bowel). Evidence indicates that late diagnosis is a significant contributor to poorer survival. Increasing screening uptake, early awareness of symptoms and early diagnosis of cancer are major priorities to improve survival.

Mental health

Suicide is a high level indicator of mental health need in a population and Tower Hamlets has the fourth highest rate in London. Schizophrenia prevalence is just under three times the national average reflecting factors such as homelessness and substance misuse. Overall prevalence of dementia is lower than London due to the younger population. However, 7% of over 65s are estimated to suffer from dementia and there is evidence of significant levels of underreporting or under-diagnosis in primary care.

End of life care

Around 1100 Tower Hamlets residents will die per year. The majority will need some form of palliative care. Based on national findings, most people when asked, state a preference for dying at home. However, Tower Hamlets has a higher hospital death rate compared to national (68% compared to 58%) and a significantly lower home death rate (17% compared to 19%). The percentage of deaths in hospitals has been slowly falling with a corresponding increase in hospice deaths. The percentage dying at home has remained relatively static.



Planned and unscheduled care

Tower Hamlets has amongst the lowest standardised first attendance rates in London. However, a lower percentage of outpatients are discharged at first appointment and the percentage of those not attending is amongst the highest in London. Elective (planned) admission rates are lower than the London average. Conversely, Tower Hamlets has amongst the highest emergency admission rates in London (particularly heart attacks, stroke, falls, accidents and fracture neck of femur). Local analysis has indicated a significant relationship between the ratio of elective to non elective admissions and deprivation. This ratio is substantially lower in higher deprivation deciles.

Internal inequalities within Tower Hamlets

Although there are significant health inequalities between Tower Hamlets and the rest of the country, there are also substantial inequalities within the borough. Life expectancy at ward level varies by around 8 years in males and 6 years for females and variation is strongly correlated with deprivation (more strongly for males than females). These differences are also reflected in deprivation related patterns of prevalence of and mortality from cardiovascular disease, chronic respiratory disease and, to a lesser extent, cancer across the borough. Disease prevalence and mortality also varies significantly by ethnicity. Age adjusted mortality rates are significantly higher in the White population compared to the Bangladeshi population for deaths from all causes, cardiovascular disease (under 75) and cancer (under 75).

Health inequalities between men and women are frequently overlooked. However, it is striking that the life expectancy gap between men and women is 5 years compared to 4 years nationally. This is consistent with a higher gap in areas of high deprivation.

Community perspectives

Findings from the Place Survey and Annual Residents Survey highlight Tower Hamlets as a place where residents feel less satisfied with their local area, have less of a sense of community cohesion and perceive higher levels of crime. Social marketing gualitative research has provided insights into resident perceptions of services and has identified strong cultural differences between ethnic groups in relation to knowledge, attitudes and belief that lead to differences in how services are used. The Tower Hamlets Involvement Network identified the following priorities issues in 2009/10 from a patient/ public perspective: quality of patient consultation with GPs, links between GPs and acute care, staff attitude at Royal London Hospital, integration of community care services, integrating mental health care and use of personal budgets by social care users.

1 Health and wellbeing in Tower Hamlets

Tower Hamlets is a place of continual change. Historically, this has been reflected in successive waves of migration. Today, it has one of the fastest growing populations in London, houses one of the world's leading financial centres and has the 2012 Olympics and Paralympics on its doorstep.

Keeping up with this change and assessing the implications for the health and wellbeing of people living and working in the borough is a constant challenge. This chapter provides a snapshot of the health and wellbeing of people in Tower Hamlets, how it is changing and the factors that influence it.

A young, diverse and growing population

The Tower Hamlets population in 2010 is estimated to be 242,000 and is characterised by diversity, mobility, high growth and a significantly higher proportion of young people than elsewhere. We have developed a bespoke population model with Tower Hamlets Council that is based on the most recent housing development data as well as the current and anticipated impact of the economic climate. This predicts that the population will increase by 20,000 over the next five years, with the fastest growth rate between 2013 and 2014. The sharp rise is based on an assumption of resumption of housing development as the economy improves. The substantial growth in population is expected to be spread unevenly across the borough. 48% is expected to be in south east of the borough, 27% in the north east, 21% in the north west and only 3% in south west.

The Tower Hamlets population is:

Young	A higher proportion of the population is aged 25 to 39 compared to London
Diverse	50% are non-white and 34% Bangladeshi 57% of under 19s are Bangladeshi 36% are Muslim and 38% Christian 8% are gay, lesbian, bisexual or transgender
Mobile	19% move in or out of the borough per year7% move within the borough per year3% of the GP registered population are newimmigrants
Growing	Rapid population growth (by 9% between 2009 and 2014)

A population with high levels of socioeconomic deprivation

As the national review of health inequalities conducted by Professor Michael Marmot has restated, health is tightly linked to socioeconomic status¹. The 'wider determinants of health' such as income, education, poverty, quality of housing, physical environment and community cohesion are profoundly linked to people's health.

Tower Hamlets is the third most deprived local authority in England based on Index of Multiple Deprivation (IMD). This is the most important factor explaining poorer overall health outcomes in Tower Hamlets than elsewhere. 79% of residents live in the 20% most deprived areas in England, compared to around 26% for London. 16 out of 17 wards are ranked in the 20% most deprived in the country and 12 in the lowest 5%.

1 Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post 2010



Underpinning these figures, Tower Hamlets has:

- The highest level of child poverty in the country:
 - 55% of under 16s are classified as living in poverty in Tower Hamlets
- Amongst the highest unemployment rates in London:
 - 14.8% of residents over 16 years were unemployed in 2009/10 (quarter 4) compared to a London average of 9.1%.
- Higher than London average long-term unemployment rates:
 - 11.2% of those claiming Job Seekers Allowance had been claiming for over a year compared to 7.3% of those claiming in London in 2008
- Lower levels of educational qualifications:
 - 15.2% of the working age population in 2009 had no qualifications compared to 11.8% in London
- High levels of non-decent housing:
 - 59% of council housing, 15% housing association and 33% of private rented dwellings were identified as non-decent in 2008.

The current economic climate is likely to have significantly affect health in the population through impacts on a number of factors including employment, housing and income. The impact of the economic downturn on unemployment in Tower Hamlets is reflected in claimant count figures. There was a steady rise in the proportion of the working age population who claimed Job Seekers Allowance, increasing from 4.6% in March 2008 to 5.7% in Feb 2009. This increase slowed over 2010 and stood at 6.0% in Feb 2010. Previous recessions have highlighted the need for interventions to address mental health and alcohol issues e.g. psychological therapies, targeted mental health promotion activities, and identification of hazardous and harmful drinking.

As the full picture on public sector spending cuts emerges, it will be important to consider health impacts on the population through changes in a range policies including income, housing, education, healthcare and social care.



Improving life expectancy but health inequalities persist

Tower Hamlets historically has had lower life expectancy and higher mortality rates than the England average. Male life expectancy is 75.3 years compared to 77.7 years nationally (2005–7), a relative gap of 3.1%. Female life expectancy is 80.4 years compared to 81.8 years nationally (2005–7), with a relative gap of 1.7%. Circulatory disease and cancer cause a greater proportion of deaths in Tower Hamlets than in other areas of similarly high deprivation.

Overall mortality in Tower Hamlets from all causes is the highest in London when adjusted for age and significantly higher than the national average. The death rate from all causes is 717 per 100,000, compared to 582 per 100,000 in England (2005–7). Despite improvements over time, there has only been a marginal reduction in this health inequality (Fig 1).

In 2006–8, Tower Hamlets had the highest rate of premature deaths (under 75) from cancer in London. when adjusted for age (144.9 per 100,00 compared to 109.8 in London and 114.0 in England). Despite steady improvements, this health inequality has not reduced and remains a major area of concern. Consequently, cancer is addressed in detail in chapter three.

Tower Hamlets also had the highest rate of premature deaths (under 75) from cardiovascular disease in

London in 2006–8 (120.5 per 100,00 compared to 79.4 in London and 74.8 in England). Cardiovascular mortality has declined over time, contributing to the increase in life expectancy,. However as the rate of decline has been no faster than in London or England, this health inequality has also persisted (Fig 2).

In addition to cardiovascular and cancer deaths, mortality from chronic obstructive pulmonary disease (COPD) is also a major contributor to high overall mortality rates. COPD mortality rates are approximately double those of London and England, driven by a high smoking prevalence of 27%, compared to 21% nationally.

Significant health inequalities within the Borough

The previous section highlighted inequalities between Tower Hamlets, London and England for high level indicators of health. However, there are also significant inequalities within Tower Hamlets.

Life expectancy

Life expectancy is highest in Millwall ward for both males and females (80.2 and 84.6 years respectively) and lowest in St Dunstan's and Stepney Green (71.9 and 78.2 years respectively), 8.3 years shorter for men and 6.4 years shorter for females (see fig 3 for ward map). Comparison with the previous year's analysis indicates that the gap between the wards with the highest and lowest life expectancies has remained similar for males (8.3 in 2003–7 compared to 8.5 years in 2002–6) but increased in females (6.4 compared to 4.6 years in the same period).

Variation in life expectancy across the borough is associated with ward deprivation (figure 4) There is a clear difference in male life expectancy between the two most affluent wards (Millwall and St Katherine's/Wapping) where it exceeds 80 years and the remaining 15 wards where it varies from 71.9 to 76.5 years. However, the association with deprivation is less clear for female life expectancy.

Cardiovascular mortality

Deaths from cardiovascular disease occur unequally across the Tower Hamlets. Four wards (Mile End East, Whitechapel, Bethnal Green North and Shadwell) have mortality rates that are close to twice the national average (see figure 3 for ward map). This contrasts again with Millwall and St Katherine's where mortality is below national average, reflecting a strong relationship between area-level deprivation and mortality.

Cancer mortality

There are also sharp inequalities in cancer across the Borough, although the relative distribution differs from cardiovascular disease. Bow East and West have by far the highest mortality (around 50% higher than national averages) with the remaining wards tending to be fairly similar except for Millwall and St Katherine's which have mortality rates 30% below the national average (see figure 3 for ward map).

Mortality between ethnic groups

A recent analysis of mortality between ethnic groups in Tower Hamlets showed that the white population has significantly higher mortality rates than other ethnic groups, including all age all cause mortality, cardiovascular disease (under 75 years) and cancer under 75 years). This relationship was consistent for both males and females.

The findings are particularly interesting given the high levels of cardiovascular disease amongst the South Asian population and high smoking prevalence amongst Bangladeshi males in Tower Hamlets. Possible explanations point to a lower alcohol consumption in Bangladeshis and lower prevalence of smoking in Bangladeshi females. We are analysing the data in further depth and linking with other data sources (e.g. primary care outcomes by ethnicity) and will use this to inform future commissioning.



Figure 3 Tower Hamlets' Local Area Partnerships (LAPs) and Primary Care Networks



Figure 4 Relationship between life expectancy and ward deprivation in Tower Hamlets Male life expectancy is lower in wards with higher deprivation

Variations in health by local area partnership

Tower Hamlets borough has been divided into eight Local Area Partnerships (LAPs), based around local wards (Fig 3) in order to drive more integrated service planning, partnership working and community development. To facilitate this further, the PCT's eight Primary Care Networks are also aligned with the LAPs. There are some variations in disease prevalence, life expectancy and mortality between and within LAPs reflecting differences in factors such as deprivation and ethnicity, These are explored in greater depth in the Tower Hamlets Joint Strategic Needs Assessment 09/10. which can be found on the local authority website

Living in Tower Hamlets

To effectively address public health issues in Tower Hamlets, a range of 'community intelligence' exercises have been undertaken. These allow residents to express their views on which issues should be prioritized and where services should be targeted. The information is then used to inform service planning and commissioning strategies within both the local authority and NHS Primary Care Trust.

The residents surveys

The two major residents surveys conducted in Tower Hamlets are the Place Survey and Annual Residents Survey. The Place Survey is a national biennial postal survey to assess people's perceptions of their local area, satisfaction with local services, community involvement, respect and community safety. In 2008, 6000 households were surveyed but the local response rate of 25% was particularly low in comparison to the national average of 41%. The Tower Hamlets Annual Residents survey covers similar issues to the Place Survey but takes the form of a face-to-face interview. As it has been conducted over several years, it provides an insight into how perceptions are changing. In 2008/9, 1180 face-to-face interviews were conducted. In general, the responses from the Place Survey are more negative than those from the Annual Resident Survey, which is likely to reflect the different survey designs.

Residents' perspectives

Overall the results provide consistent evidence that compared to London. Tower Hamlets residents feel less satisfied with their local area, have less of a sense of community cohesion and perceive higher levels of crime and antisocial behaviour.

Some key findings from the Place Survey (2008) are set out below with London figures in brackets.

- 69% of Tower Hamlets residents were satisfied with their local area (75%)
- 64% of people over 65 were satisfied with their home and neighbourhood (77%)
- 63% believed people from different backgrounds get on well (76%)
- 43% felt they belong to their neighbourhood (52%)
- 50% felt that people in the area did not treat each other with respect (38%)
- 62% reported having been treated with respect by local public services (67%)
- 46% perceived a high level of antisocial behaviour in the local area (27%)
- 61% viewed drug use or drug dealing as a big problem (37%)
- 47% perceived drunk and rowdy behaviour as problem in the area (36%)

The Annual Residents Survey (09/10) offers the following additional insights:

- 65% of residents rated local health services as good or excellent. This was not significantly different from London and had not changed from the previous year.
- There was a significant rise in concern over affordable housing and lack of jobs, compared to the 08/09 survey.
- 61% rated parks and open spaces as good or excellent, which was significantly lower than London (70%).
- The rating for leisure and sports facilities was 47% and this was similar to London.
- Satisfaction with nursery and primary education was similar to London levels

Challenges to improving satisfaction

An important factor in interpreting how Tower Hamlets compares to other places relates to the relative levels of difficulty in improving satisfaction in a particular area. Based on the Place Survey, Ipsos Mori has attempted to quantify this using an 'Area Challenge' Index. This takes into account features of a local area including deprivation, ethnic diversity, young people, population churn, housing conditions, urbanity and region. By this measure, Tower Hamlets is the third most 'challenged' borough in London after City & Hackney and Newham.

Tower Hamlets Involvement Network (THINk)

Local Involvement Networks have been established in every area of England to help people influence or change the way their local NHS and social care services are delivered. In Tower Hamlets, the local involvement network, called Tower Hamlets Involvement Network (THINk), was established in September 2008. THINk is independent of the local authority and NHS and its remit encompasses all health and social care services including local hospitals, general practices, care homes and pharmacists.

It has gathered valuable insights on local health and social care needs and perceptions of services using questionnaires, interviews, surveys, outreach programmes and attendance at health and social care events. THINk have identified the following priority issues from a patient/public perspective in 2009/10:

- Quality of patient consultation with GPs
- Links between GPs and acute care
- Staff attitude at the Royal London Hospital
- Integration of community care services
- Integration of mental health care
- Use of personal budgets by social care users.

The Improving Health and Wellbeing consultation in 2009 and other local surveys suggest that residents have seen improvements in services over the past three years. Integration of services through health centres is welcomed, although there was a concern about ensuring that local access was not lost.

Social marketing

Social marketing, as defined by the Department of Health, is "the systematic application of marketing concepts and approaches to achieve behavioural goals relevant to improving health and reducing health inequalities". Drawing on techniques from commercial marketing, it recognises that behaviour change will not occur simply through giving information and urging people to be healthy. Instead, social marketing attempts to understand why people behave as they do and how they may best be supported to make healthy life choices.

In 2007, the Department of Health published Healthy Foundations, a report of social marketing research. The research explored the English population and created segmented population groups with common characteristics, for example, a similar age or life-stage, similar circumstances or environments, or similar attitudes and beliefs towards health and health issues. From this point, the research explored drivers of behaviour across the six national public health priority areas: smoking, alcohol, sexual health, obesity, substance misuse and mental health. Tower Hamlets is an early adopter of the application of this research and we are using it inform local segmentation of the population to target our interventions more effectively. For example, we are currently using the research as the basis for a

project around understanding how services could be configured more effectively to engage white males aged 30–50 in addressing risk factors for vascular disease.

Social marketing in Tower Hamlets

Since 2007, we have commissioned a number of social marketing projects on a range of health issues including cancer screening, childhood obesity, smoking, immunisation, sexual health, GP access, diabetes education, mental health stigma and physical activity. This provides further evidence of the issues highlighted above including:

- The struggle of parents in Tower Hamlets to help their children lead healthier lives due lack of available places to play safely, the proliferation of fast food outlets, low incomes, peer pressure (and gang pressure) and social norms.
- Strong cultural differences between different ethnic groups in relation to knowledge, attitudes and beliefs about services that lead to differences in how services are used e.g. screening, immunisation and smoking cessation.
- Fear as a key factor influencing behaviour, whether this relates to fear of finding out what is wrong (e.g. screening), fear of healthcare environments (e.g. dental services), fear of taking on people with mental illness (e.g. tackling stigma associated with mental illness) or fear of breaking from activities that provide social benefits (e.g. smoking, paan chewing).
- Despite a generally good knowledge about what constitutes a healthy lifestyle, the research showed some misconceptions, for example relating to what is 'healthy'.

These insights are being used to inform service reconfiguration and health promotion campaigns at both a network and borough level.



Maternity and Early Years

A critical stage in life

There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. This is reinforced by the Marmot Review which emphasises that action to reduce health inequalities must start before birth and be followed through the life of the child. For this reason, giving every child the best start in life is their highest priority recommendation.

During pregnancy, the foundations of future health and wellbeing are laid down and parents are particularly receptive to learning and making changes. Evidence relating to neurological development and the impact of stress in pregnancy and to the importance of attachment, make a clear case for early intervention and prevention; this is particularly true for children who are born into disadvantaged circumstances.

Child Poverty

Tower Hamlets has the highest rate of child poverty in London. 55% of Tower Hamlets under 16s are classified as living in poverty (defined as less than 60% of the national median income). Free school meals entitlement is the highest in the country, with 52% of pupils entitled to free school meals. One in twelve Tower Hamlets children live in homeless households.



Birth rate

There were 4,255 births to women resident in Tower Hamlets in 2008/9. This equates to a birth rate of 68 per 1000 which is close to the London average and higher than England. 45% of births were to Bangladeshi mothers.

Improving pregnancy outcomes

Poor outcomes in pregnancy, such as low birth weight and perinatal mortality, are more likely in Tower Hamlets due to a high prevalence of a number of risk factors, including high deprivation, high smoking rates in the white population and high (but improving) late booking rates and rising levels of gestational diabetes. The Department of Health National Support Team for Infant Mortality (IMNST) visited Tower Hamlets in February 2010 and congratulated Tower Hamlets on its approach to strategy and partnership working. Recommendations were made to continue building on this approach which have been incorporated into the Maternity Health Improvement Strategy and associated action plan.

Maternity Access

Performance for early maternity access (booking by 12 weeks 6 days) reached 83.7% in 2009/10 and continues to improve towards the target of 90% by Q4 2010/11. NHS Tower Hamlets has been working with the Maternity Services at Barts and the London NHS Trust to deliver these improvements.

Low birth weight and infant mortality

Tower Hamlets has a higher proportion of newborn babies with a low birth weight (<2500g) compared to London; the highest are to Bangladeshi mothers. Despite this, infant and perinatal rates are not significantly different to London or England.

Smoking

Smoking in pregnancy is the largest preventable cause of foetal and infant ill-health and death. The Stop Smoking service includes a dedicated service for all pregnant women in Tower Hamlets, which extends into their postnatal period, by ensuring support is available in community settings such as community clinics, children centres and clients' homes.

Tower Hamlets has amongst the lowest rates of smoking in women during pregnancy. 5.4% of women delivering at RLH were recorded as smokers in Q4 2009/10 compared to 14.1% for England. However, this low rate masks significant differences by ethnicity with smoking rates highest in white women (16.2%) and lowest in Bangladeshi women (1%) in 2007/08.

Nutrition

Nutrition is essential for growth and general health. Standards of child nutrition in Tower Hamlets can be measured through three key indicators: breast feeding rates, oral health and childhood obesity at reception year.

Exclusive breastfeeding is promoted as the best form of nutrition for infants during their first six months, continuing at least until solids are tolerated, and ideally, alongside solids, up to about age two years. Breast feeding initiation rates are higher than the England average (Q2; 2009/10 data), and continuation of breast feeding to 6-8 weeks is higher than both the England and London average (Q4 2009/10 data). The breastfeeding strategy is driven by the Baby Friendly Initiative which takes a whole systems approach and is integral to the ongoing improvements being seen in breastfeeding rates.

Tooth decay rates in five year olds have historically been higher than London but there is recent evidence that levels are getting closer to the London average

The prevalence rate of gestational diabetes has been increasing and in 2007 was highest in Bangladeshi women (18.7%) and African women (12.4%) and lowest in White women (5.5%) in Tower Hamlets. The foundations for virtually every aspect of human development – physical, intellectual and emotional— are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.

To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences.

Later interventions, although important, are considerably less effective if they have not had good early foundations.

The Marmot Review

Childhood obesity

Results from the National Child Measurement Programme show that the number of children at risk of being obese aged 4–5 (Reception) fell slightly to 13.4% (from 13.7%) and rose to 25.7% for children aged 10–11 (Year 6) in 2008/09 (from 24.4%). Tower Hamlets ranked 5th highest in London for prevalence in Reception year, and 2nd highest in London (and England) for obesity prevalence at Year 6. The proportion of obese 4–5 year olds has been decreasing over the last two years whilst the proportion of 10–11 year olds who are obese has increased.

Local data (from the Tell Us Surveys) showed that our children are less likely to participate in physical activity or to eat enough fruit and vegetables, compared to the average for England.

Tower Hamlets, in common with many other inner city areas, has a number of factors that help explain our high levels of childhood obesity. Nationally, childhood obesity is strongly correlated with deprivation and the percentage of accessible green space. Tower Hamlets has the third lowest percentage of publicly accessible green space nationally. Concerns about safety, including high volumes of traffic and fear of crime, have been identified as barriers to walking, cycling and use of local green spaces for active play, sport, walking and running. Barriers to healthy eating include lack of access to affordable, healthy food and widespread availability of relatively cheap, 'energy-dense' fast foods.

Our local multi-agency *Healthy Weight, Healthy Lives in Tower Hamlets* strategy sets out how we are tackling the local barriers to healthy eating and physical activity with the goal of stemming the rising tide of obesity. Local NHS funding and additional national funding (for the Healthy Borough Programme until March 2011) has enabled strategic partners (Local Authority, NHS, voluntary sector, private sector and local people themselves) to make it easier for more local children and families to eat healthily and be physically active as set out below.

Promoting healthy environments by:

- Integrating physical activity and access to healthy food into planning for the built environment and developing proposals for a 'green grid' for Tower Hamlets
- Improving walking and cycling routes
- Promoting physical activity in parks and open spaces, active play and access to swimming for women and girls
- Improving access to healthy food including a food for health awards scheme for restaurants, cafés and fast food outlets and the 'buywell' projects which increases the availability of fresh fruit and vegetables in convenience stores

Promoting healthy organisations:

Through work place policies and particular interventions in early years and schools settings.

Promoting healthy communities:

This includes funding for third sector organisations and local people to tackle barriers to physical activity and healthy eating (e.g. 'can do' community grants of up to \pm 500), active travel projects (e.g. Ocean estate), parenting initiatives and social marketing and communications, such as Change 4 life branding around the borough that mirrors national TV advertising.

Mental health in children

Prevalence of mental health disorders in Tower Hamlets children is estimated to be similar to national averages (just under 1 in 10). Data from Children and Adolescent Mental Health Services (CAMHS) suggested that a lower proportion of children with mental health problems were of Bangladeshi origin relative to the high proportion of Bangladeshis in the under 19 population. This is a finding that is being explored further in a more detailed needs assessment.

Injuries to children and young people

Tower Hamlets has the second highest rate of hospital admissions for unintentional and deliberate injuries to children and young people in London, (123.1 admissions per 10,000 population in 2008–09). The vast majority of these admissions are for unintentional injury, with only 4.3 per 10,000 population being for deliberate injury.

The number of children killed or seriously injured in road traffic accidents in Tower Hamlets was 9 per billion vehicle kilometres in 2006–08 (ranking 15th of 33 London boroughs), a 66% fall since 1994–98.

Safeguarding children

The number of children on the Child Protection Register increased from 77 in 2004/05 (15.9 per 10,000) to 267 in 2008/09 (38.9 per 10,000) with the greatest increase in Bangladeshi children. This increase is explained primarily by better ascertainment. The percentage of deregistration (an indicator of effective child protection work) was lower in 2008/9 (2-3%) compared to the England average (4%). Conversely, trends in rates of Looked After Children have fallen between 2004/5 and 2007/8, possibly reflecting improvements in prevention.

Staying healthy – preventing disease

The prevention of disease through the adoption of healthy lifestyles is a critical component of public health practice. The latter chapters of this report will focus on healthy lifestyles and cancer, particularly cancer prevention, and only headline figures will be presented here.

Targeting smoking

Smoking prevalence is significantly higher in Tower Hamlets than nationally. 27% of adults are smokers compared to 21% in England (Health Survey for England 2008). This equates to around 60,000 smokers Smoking prevalence is particularly high amongst Bangladeshi males (45%). 20% of children under 15 have tried a cigarette and 40% of retailers have been found to sell cigarettes to under 18s.

Reflecting these figures, Tower Hamlets has the highest death rates linked to smoking in London. As the single most preventable cause of death, tackling tobacco use is therefore a key priority.

Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.

The Marmot Review



Diet, physical activity and obesity

Fewer adults in Tower Hamlets report eating five pieces of fruit and vegetables per day. 90% do not reach this target, compared to 70% nationally. Based on the National Active People Survey 2009 a lower proportion of the adult population participate in sport/active recreation (18% compared to 21% nationally) and participation rates are particularly low in Bangladeshi females. However, findings from the Tower Hamlets Adult Healthy Lifestyles Survey outlined in the chapter 2 suggest that overall levels of physical activity are similar to national levels. Based on modelling data from the Health Survey of England around 40–50,000 people in Tower Hamlets are estimated to be obeser.

Alcohol

3 in 10 of Tower Hamlets children have ever had an alcoholic drink compared to 7 in 10 nationally (reflecting the large Muslim population in the borough). Similarly, 1 in 2 of adults say they have not had any alcoholic drinks in the past year. In the White population, 4 in 10 are classified as hazardous or harmful drinkers compared to 2 in 10 nationally. Despite low prevalence of alcohol use, alcohol related admission rates are higher than London averages.

Sexual health

The incidence of sexually transmitted infections (STIs) in Tower Hamlets has risen in 2008-09 and is ranked the 8th highest in the country. Gonorrhoea, chlamydia and anogenital herpes diagnoses have all increased, with higher numbers of new infections seen in men compared to women. Amongst women, 20–34 year olds were most affected, whereas in men the 20–44 year old age group was most affected. Some of the increase in STIs can be explained by more testing for chlamydia and gonorrhoea as part of the chlamydia screening programme.

Teenage Pregnancy

Teenage pregnancy is most common amongst the most deprived and socially excluded young people. Difficulties in young people's lives, such as poor family relationships, low self-esteem and dislike of school, contribute to young people's risk. Teenage pregnancy is a complex issue that can have negative consequences on the mother and child. They are more likely to suffer from poor health outcomes, poor emotional health and poverty.

The teenage pregnancy rate in Tower Hamlets is currently below England and London averages following recent downward trends in 2008. There has been a 42.1% decline in the under-18 teenage conception rate between 1998-2008. In 2008, 53% of conceptions under the age of 18 led to an abortion. This is higher than the average for England (50%) but lower than the average for Inner London (60%).

Tower Hamlets rates are now at their lowest level for 20 years and significant investment has been made locally to implement a broad range of measures needed to address unplanned pregnancy and support for teenage mothers.

The reduction in the teenage conception rate was achieved through a wide range of programmes including improved sexual health advice and contraceptive services for young people and active engagement of all key mainstream delivery partners who have a role in reducing teenage pregnancies: health, education, social services, youth support and the voluntary sector.

HIV and Tuberculosis

The prevalence rate of HIV in Tower Hamlets in 2008 was 5.6 per 1000 population aged 15-59

years, slightly higher than the London prevalence of 5.0 per 1000 and England's rate of 1.7 per 1000 population. This represents a 34% increase in HIV diagnosis since 2005. Most of the HIV infection (71%) was acquired through sex between men.

In 2008, 23% of HIV infections in Tower Hamlets were diagnosed late compared to 31% on average in London. 7% of late HIV diagnoses were in men having sex with men (MSM) compared to 58% in heterosexuals (mainly African communities). An HIV awareness programme and HIV outreach testing targeting MSM and African communities is in place and will be reviewed on a regular basis to ensure effectiveness and value for money.

Tuberculosis (TB) prevalence has been rising slowly over the past few years and has reached 65.3 per 100 000 population in 2009, significantly higher than the London average of 45.1 per 100 000 population. A joint programme of action with local partners in Tower Hamlets is currently being implemented to raise awareness about TB with local communities, promote early diagnosis in primary care and improve treatment completion rates through community outreach work, as well as delivery of directly observed therapy (DOT) with pharmacies.

Immunisation

There were significant improvements in the childhood immunisation programme during 2009/10 as a consequence of organising a systematic call and recall programme alongside regular monitoring of performance. Children who have not taken up immunisation can now be identified by practices so families can be followed



Figure 5: Uptake of MMR1 vaccine for children aged 2 Source: NHS Information Centre up to encourage vaccination uptake (Fig 5). A Network Locally Enhanced Service has been produced and this has encouraged Network management teams to invest time to improve the immunisation programme. Uptake of the seasonal flu vaccine for over 65 year olds reached 76% in 09/10. 55% of under 65 year olds with long term conditions also received a vaccine, which was above the national average 51% for the winter period 09/10.

Long Term Conditions

Tower Hamlets has the second highest age adjusted mortality rate in London from deaths amenable to healthcare. Most of these are due to cardiovascular disease, cancer and chronic respiratory disease. For these conditions, Tower Hamlets has either the highest or the second highest mortality rates in London.

Around 9000 people aged 40 to 74 are estimated to have a 20% risk of a cardiovascular disease event in the next ten years and we are targeting this population through the Health Check Programme in primary care. This programme aims to identify 40 to 74 year olds at high risk and reduce risk through controlling blood pressure, managing cholesterol and promoting healthy lifestyles. These measures can achieve substantial reductions in risk of heart disease, stroke and diabetes.

Table 1 shows the observed prevalence of long term conditions in Tower Hamlets compared to England.

Prevalence tends to be lower due to the substantially younger population in Tower Hamlets However, prevalence by age bands is generally higher reflecting the impacts of deprivation and, for some conditions, ethnicity (eg higher diabetes prevalence in South Asian populations).

In order to assess the extent to which long term conditions are identified and therefore treated effectively we have used models to estimate the number of cases expected based on our population characteristics (eg deprivation, ethnicity). This modelling suggests significant under-diagnosis for coronary heart disease, hypertension, chronic kidney disease, dementia and chronic obstructive pulmonary disease (table 1).

Outcomes in primary care are generally above London averages for secondary prevention of vascular disease through management of blood pressure and cholesterol control in people with existing vascular disease. In 2008/9, 85.3%. of those on coronary heart disease registers had cholesterol controlled compared to 79.8% in London (best performance in London) and 89.8% had blood pressure controlled compared to 89.2% (10th best performance out of 32 PCTs). Conversely, performance on control of diabetes (as measured by an indicator called HbA1C) was significantly poorer in 2008/9 compared

	Observed Tower Hamlets Prevalence*	Observed England Prevalence*	Number on Tower Hamlets register *	Estimated undiagnosed or unreported**	Estimated% Undiagnosed
Diabetes	6.0%	5.40%	11872	359	3%
CHD	1.80%	3.40%	4685	2814	38%
Hypertension	8.20%	13.40%	20981	13480	39%
CKD	1.80%	4.30%	3574	5494	61%
Dementia	0.20%	0.50%	478	1094	70%
COPD	1.20%	1.60%	2950	7349	71%

CHD = Coronary Heart Disease; CKD = Chronic Kidney Disease; COPD = Chronic Obstructive Pulmonary Disease

Table 1: Expected vs. Observed Prevalence of common long term conditions 09/10 * = *QOF* ** = *modelled*

to London. 58.5% of those on diabetes registers had diabetes controlled (HbA1C 7.5 or less) compared to 63.6% in London (2nd worst performance in London). Effective diabetes control requires a combination of lifestyle change (eg healthy eating, physical activity and stopping smoking) and medication where approriate. Poorer control of diabetes is consistent with areas of high deprivation and a higher levels of lifestyle risk factors. For these reasons, 09/10 saw a significant investment in primary care to improve outcomes in people with diabetes.

On most primare care outcome indicators there are wide variations between practices that are not necessarily linked with differences in practice population. This variation is an important reason for developing standardised models of care ('care packages') through GP networks across the borough. Finally, secondary care standardised admission rates for CHD, stroke, heart failure, coronary heart disease and COPD are the highest in London.

Carers

At least 3.7% of the Tower Hamlets population (around 9,000 people) provide 20 hours or more unpaid care per week. Of this figure 5,800 people provide 50 hours or more unpaid care per week, a higher proportion than any other inner London borough. We recently conducted an assessment of the health needs of carers and this highlighted the importance of supporting their wellbeing through preventative and early intervention services e.g. respite breaks and health checks.

Cancer

Tower Hamlets has the highest cancer mortality in London. This is driven to a significant extent by high incidence and mortality from lung cancer and reflects the high prevalence of smoking in the Borough. However, apart from lung cancer, incidence of common cancers is either similar or lower than elsewhere. One year survival from cancer is in the bottom 10% nationally and this is particularly poor for breast, colorectal and prostate cancer. Cancer screening uptake is lower than national averages (breast, cervical and bowel). Evidence indicates that late diagnosis is a significant contributor to poorer survival. Increasing screening uptake, early awareness of symptoms and early diagnosis of cancer are priorities to improve survival. As a major contributor to poorer life expectancy in Tower Hamlets, the prevention, early identification and effective treatment of cancer is considered in depth in Chapter Three.

Planned Care

Planned care relates to any contact with health services that has been arranged in advance and includes elective hospital admissions, GP and outpatient appointments.

Based on NHS Comparators data 08/09, Tower Hamlets has amongst the lowest standardised outpatient first attendance rates in London. Whilst average outpatient to follow up is similar to London (2.3 compared to 2.2), the percentage of outpatients discharged at first appointment is lower in London and the percentage of outpatients who did not attend is the second highest. Standardised elective admission rates are the lowest in London. Elective inpatient rates and day case rates are correspondingly low (day case rates are the lowest in London).

Data from the 09/10 GP survey found that the percentage of patients registered with Tower Hamlets practice reporting that they were able to get an appointment within 48 hours (80%) was similar to the London average. Satisfaction with telephone access, ability to book an appointment in advance and opening hours was higher although ability to get an appointment with a specific GP is lower.

Unplanned Care

Unplanned care is care delivered without an appointment. It ranges from serious conditions to relatively minor illness and is required 24 hours a day.

Tower Hamlets had the second highest standardised emergency admission rates in London in 2008/9 (96 per 1000 compare to 78

per 1000). Analysis of A&E attendances in 2006 showed that the highest levels of usage and repeat attendances were seen in 0–4 years olds and 20–29 years olds of which a high proportion were for minor ailments.

The most common causes of admission are circulatory disease, respiratory conditions and accidents. In 2007/8, admission rates for long term conditions were the third highest in London (694 per 1000).

Findings of high emergency admissions and low elective admissions are linked to levels of deprivation in the Borough. Recent analysis to understand local health inequalities in greater depth has focussed on analysis of health and wellbeing data by deprivation deciles. This has highlighted that the secondary care costs of those living in the most deprived deciles in Tower Hamlets are almost twice those living in the least deprived (£227 per head compared to £117 per head). Furthermore, the ratio between elective and non-elective admissions is around three times higher in the least deprived decile compared to the most deprived. This analysis has identified the importance of understanding health inequalities at below ward level (e.g. lower super output area) to inform locality and LAP level clinical commissioning as well as service integration a very local level (e.g. estate, neighbourhood).

Mental Health

As would be expected in an area with high levels of socioeconomic deprivation, Tower Hamlets has a high prevalence of mental health problems. Suicide is a high level indicator of mental health need in a population and Tower Hamlets has the second highest rate in London. 1.1% of the Tower Hamlets population (2850 people) suffer from schizophrenia, bipolar disorder and other psychoses, higher than the national prevalence of 0.8% (QOF 2009/10). In addition, admissions for schizophrenia are substantially higher than the national average (81 vs. 31 per 100,000 in 2006/07). These figures reflect higher risk factors for these conditions, including homelessness and substance misuse.

Overall prevalence of dementia is lower than the national average due to the younger population (0.2% vs. 0.5%). However, 7% of the over 65s are estimated to suffer from

dementia and there is evidence of significant underreporting or under-diagnosis in primary care.

End of Life Care

End of life care covers the care of people with progressive, incurable disease, provided in all settings in the last year of life, includes care to patients, carers and family as well as bereavement care. Around 1100 Tower Hamlets residents will die per year based on current mortality rates. It is estimated that around 900 people per year will need some form of palliative care but the level of care needed will vary considerably. The main causes of death are circulatory disease (33%), cancer (31%) and respiratory disease (12%). Most people, when asked, state that they would like to die at home if possible (Delivering Choice Programme, 2008). Tower Hamlets has a higher hospital death rate and a lower home death rate compared to the national average (68% compared to 58%, and 17% compared to 19%, respectively). The percentage of hospital deaths has been falling (from 71% in 2005), as has the percentage of death in hospices (from 12% in 2007 to 9% in 2009). The percentage of deaths in nursing and care homes has increased slightly (from 2% in 2006 to 4% in 2009), and the percentage of deaths at home remains relatively static.

Work to decrease the number of hospital deaths has been a priority and has included the development of a Palliative and End of Life Care Pathway for Tower Hamlets, development of the Tower Hamlets Palliative Care Centre, and education of community-based staff to reduce unnecessary admission. In addition, the use of the End of Life Care tools has been encouraged, specifically the Gold Standards Framework (delivered via an Enhanced Service) and the Liverpool Care Pathway in the community. A Delivering Choice Workstream has been established for hospital care to improve discharge, reduce admission via A&E and address patients' preferences for place of care.

Summary and recommendations

This section has summarised the important health and wellbeing issues in the Tower Hamlets population. It sets out a picture of generally poorer health outcomes than elsewhere linked to the high levels of socioeconomic deprivation and lower levels of healthy behaviours. The recommendations emerging out of this analysis are set out in the next page.



Priorities emerging out of this analysis are as follows:

Recommendation	Evidence
Continue to address wider determinants (eg income, housing, education, crime) through the Tower Hamlets Community Plan	Tower Hamlets 3 rd most deprived local authority area. Strong association between health and social deprivation
Ensure that services are responsive to health impacts of economic climate	Evidence from economic downturns highlight impacts on mental health, alcohol problems, homelessness
Maintain focus on three major killers: cardiovascular disease, cancer and chronic respiratory disease	Highest or second highest mortality rates and admission rates in London,
Continue to ensure that programmes impacting on health and wellbeing address health inequalities within the borough	8.3 year life expectancy gap in males and and 6.4 year gap in females in wards with highest and lowest life expectancy.
Sustain efforts to slow down and reverse trends in childhood obesity	5 th highest levels of childhood obesity in 4–5 year olds in London,and 2 nd highest levels in 10–11 year olds
Sustain substantial progress in increasing MMR uptake	92% uptake of second MMR in 2010
Continue to prioritise programmes to increase healthy behaviours in the population	27% smoke compared to 21% nationally 90% adults eat less than 5 a day compared to 70% nationally. Levels of harmful drinking in white population twice national level.
Continue to prioritise programmes to prevent, identify and effectively manage infectious disease	8 th highest incidence of sexually transmitted diseases nationally, higher prevalence of HIV and TB than London
Sustain progress on reducing rate of teenage pregnancy and supporting teenage parents	42% decline in under 18 teenage conceptions
Continue programmes to develop, implement and monitor integrated, evidence based care packages for identification and management of long term conditions (eg diabetes, vascular disease, COPD)	High death rates from long term conditions. Variations in outcomes between practices. Evidence of underdiagnosis.
Continue to implement and strengthen cancer programmes to increase screening uptake, early awareness of symptoms and early diagnosis	Highest cancer mortality in London. Poor one year survival
Continue to prioritise support for carers	9000 people provide 20 hours or more of unpaid care per week and 5,800 provide 50 or more hours (the highest in London as a percentage)
Continue to prioritise identification and effective management of mental health problems	Fourth highest suicide rate in London, higher prevalence of severe mental illness, evidence of significant underdiagnosis or underreporting of dementia
Maintain improvements in helping people die in the setting of their choice	68% of Tower Hamlets residents die in hospital compared to 58% nationally

2 Tower Hamlets adult health and lifestyles survey

We know that there is a higher prevalence of lifestyle risk factors in the Tower Hamlets population and that at high level this is linked to the levels of deprivation in the borough.

The annual public health report last year focused on what we were doing around addressing tobacco use, obesity and alcohol use in the Borough. However, one of the recurring themes highlighted was the lack of local data on healthy lifestyles. The data used was either extrapolated from national surveys or relied on old survey data.

One of the lessons that we have learnt over the past years commissioning services to promote healthy lifestyles in the Borough is the importance of cultural, social and economic factors operating at very local level that can affect the effectiveness of approaches.

Furthermore, as the locality and integration agendas have progressed across the Partnership, the need for rich local data on healthy lifestyles to provide insights into how to target healthy lifestyles interventions has intensified.

These considerations motivated the commissioning of an adult healthy lifestyles survey in 2009 which would provide up to date insight on behaviours within the population by social, economic, geographical and cultural factors. The findings are intended to inform more effective and equitable commissioning of healthy lifestyles within different segments and geographies of the Tower Hamlets population.

The survey design

The survey was developed between NHS Tower Hamlets Public Health Directorate and Ipsos Mori. The questionnaire collected data on demography (age, gender, ethnicity), wider determinants of health (deprivation, educational attainment, literacy, housing, employment and migration) and health factors (long term condition, mental health status and body mass).

This dataset then provided the basis for analysing the four lifestyle behaviours of interest: tobacco use, alcohol,

physical activity and diet. Statistical analysis was used to explore whether these varied significantly by demography, social factors, locality and health status.

The study sample

Face-to-face interviews were conducted with 2671 residents aged over 16 years across the Borough. The survey reflected the age and ethnicity of the Tower Hamlets population: 52% of respondents were under 35 years, 33% aged 35-54 years and only 15% were over 55 years old. 47% respondents were White, 36% Asian, 10% Black, 2% Mixed and 5% Other.

Findings on tobacco use

Prevalence

27% of residents reported that they were current smokers. This is much higher than the national average of 21%. 69% of current smokers expressed a desire to stop smoking, which is similar to national figures. Of the non smokers, 33% had previously smoked and 15% of these had given up in the previous year.

Demography

34% of males were current smokers compared to 20% of females. There were important gender differences in smoking prevalence by ethnicity. In the White population, the proportion of female smokers and male smokers was not significantly different. However, in the Asian and Black populations a much higher proportion of males smoked than females (Fig 6).

Similarly, smoking prevalence varied by age within certain ethnic groups. However, this variation was



only significant in the Black population in which those under 35 year olds were significantly more likely to smoke than older age groups.

Wider determinants

Smoking prevalence was clearly related to levels of deprivation, with a strong relationship seen between increased smoking prevalence and area-level deprivation. 30% of residents living in the most deprived fifth of the population (as measured by the index of multiple deprivation) reported smoking compared to 23% in the least deprived.

Headline findings on tobacco use

Self-reported smoking prevalence was significantly higher than the national average.

Smoking prevalence was highest in Asian and Black males and younger black residents.

Smoking is more common in deprived areas.

People with long term condition or poor mental health are more likely to be smokers



Figure 6 Smoking prevalence by gender and ethnic group Source: Tower Hamlets Adult Health & Lifestyle Survey 2009 Other social inequalities in smoking include a higher smoking prevalence amongst those not in employment, education or training (NEET status) where 30% of respondents smoked, compared to 26% of those in employment, education or training.

Figure 7 shows that respondents with lower levels of education had a higher smoking prevalence. For example, 29% of respondents with levels of education below AS level stated that they smoked compared to 24% with a higher level of education. Similarly, 32% of those with poor literacy in their first language smoked compared to 23% of those who rated their first language literacy as good. However, those with poor English literacy had a lower smoking prevalence than those who rated it as good (22% compared to 28%). This is likely to relate to the very low proportion of Asian women who smoke and the relatively poorer English literacy in this population. A similar picture was found in those who rated their English fluency as poor.

Smoking prevalence was higher amongst those who lived in social housing (council homes, housing associations etc.) than those who rented or owned in the private sector (29% vs. 21%).



Similarly, smoking prevalence was much higher in respondents who had changed address in the previous year (34%) than those who had been at the same address for longer (26%). The highest prevalence was seen in migrants from within Europe but outside the UK (38%) and those who moved within the borough (37%). It is more difficult to conduct health promotion within transient populations, so this finding highlights the importance of tackling these challenges.

Health and tobacco use

Those who reported current smoking were significantly more likely to have long term health conditions than non-smokers (31% vs. 26%). Given the health benefits of smoking

Wider determinants that were related to smoking:

- Area deprivation
- Low education
- Unemployment
- Living in social housing
- Poor English literacy and fluency
- Recently moved to the area



Figure 7

Smoking and wider determinants of health Source: Tower Hamlets Adult Health & Lifestyle Survey 2009 cessation, this demonstrates the significant potential health gains that may be made by tackling smoking in this population.

Worse mental health was associated with higher levels of smoking. 34% of smokers were in the bottom fifth of mental health scores compared to 20% of non smokers. it is well established that smoking prevalence is higher in people with mental health problems and this contributes to high levels of physical illness in this group. This result highlights the importance of overcoming barriers to smoking cessation amongst those with poor mental health to achieve substantial gains in health.

Findings on alcohol

Prevalence

50% of respondents stated that they had drunk alcohol in the past year. Hazardous drinking refers to drinking above recommended levels (see box). Harmful drinking refers to drinking at levels that result in harm either to oneself (eg liver cirrhosis, injury) or to others (eg violence, road traffic accidents). 43% of drinkers consumed alcohol in a manner that was either hazardous or harmful to their health. This was around twice the national average.

Headline findings on alcohol use

Overall alcohol consumption in Tower Hamlets was lower than the national average reflecting the high percentage of muslim people in the population

Harmful or hazardous drinking was twice as high as national levels in drinkers

Alcohol consumption was highest in the white population

Younger drinkers were more likely to drink in a harmful or hazardous way than older residents

Hazardous or harmful drinking in drinkers was at least as prevalent in more affluent areas as more deprived areas (even when controlling for ethncity)

Demography

Men were more likely to drink than women (54% vs. 45%) and were more likely to drink at hazardous or harmful levels (24% vs. 19%).

Figure 8 shows that drinking was most common amongst the young, white population in Tower Hamlets. There was also strong evidence that men in the White and Asian population were more likely to drink than women, but no significant differences were seen in the Black and 'Other' ethnic groups (although this may be due to small numbers)





Prevalence of harmful/hazardous drinking by age and ethnic group

Source: Tower Hamlets Adult Health & Lifestyle Survey 2009

Wider determinants that were related to hazardous or harmful alcohol use:

- More affluent area (if white)
- Educated
- Employed
- Living in the private housing sector
- Recently moved to the area

A high proportion of drinkers consumed alcohol in hazardous or harmful patterns across all ethnic groups. However, the proportion of drinkers in the White Population was particularly high (fig 8).

There were also age-related trends in levels of hazardous or harmful drinking. Highest levels were in the 16-34 year age groups (51% of drinkers). Younger white men were at highest risk of hazardous or harmful drinking.

Wider determinants

Relating alcohol use to deprivation is complicated by the consideration that the Bangladeshi population tends to live in the higher deprivation quintiles in the Borough. However, amongst the white population, hazardous or harmful drinking was at least as prevalent in the more affluent areas (42% is most deprived areas vs. 45% in the least deprived areas).

Hazardous and harmful drinking was more common amongst people who were employed than those who were unemployed (30% and 9% respectively), and amongst those who were educated (GCSEs or above) compared to those who had no qualifications (27% and 9% respectively amongst all residents, and 44% and 19% in the white population). Consistent with this, residents living in the private housing sector were more likely to drink to harmful levels than those living in social housing (36% compared to 9%) when controlling for ethnicity, gender and age.

Migrants (defined as respondents who had changed address in the previous year) were significantly more likely to be drinkers than non migrants (68% vs. 46%) and to have patterns of 'risky drinking' (35% vs. 19%). This remained the case when the analysis was restricted to the white population. 51% of migrants drank at hazardous or harmful levels compared to 34% of non-migrants. The highest levels were seen in migrants of white ethnicity from outside the borough but within the UK (60%).

Health and alcohol consumption

Alcohol consumption was not related to whether the respondent reported a long-term condition or not, except in the white population where those with a long term condition were less likely to report alcohol use (68% vs. 86%). It is likely that low socioeconomic status and age play a part in this relationship.

There was no relationship seen in this survey between mental health and alcohol consumption.

Recommended levels of alcohol consumption: Men - 3-4 units of alcohol per day and no more thant 21 units over a week.

Women – 2-3 units per day and no more than 14 over a week.

A pint of beer is around 2.8 units and a standard glass of wine is 2.1 units.



Findings on physical activity

The national minimum recommended level of physical activity for a healthy life is 30 minutes of moderate activity on at least five days per week.

Prevalence

68% of respondents reported not meeting the recommended level of activity. This is a similar level to the findings of the 2008 Health Survey for England (HSE) which reported 66% nationally. 74% of residents stated that they exercised for 30 minutes at least once per week.



Figure 9 Physical inactivity by age Source: Tower Hamlets Adult Health & Lifestyle Survey 2009

Headline findings on physical activity

- Levels of physical inactivity was similar in Tower Hamlets to the national average.
- Older people were more likely to be physically inactive than younger people.
- Physical activity levels were not significantly associated with gender and ethnicity
- Physical inactivity was more common amongst of low socioeconomic status
- Residents with long term conditions and poor mental health were less likely to achieve adequate levels of physical activity.

Demography

Levels of physical inactivity were not significantly different between men and women. Compared to the HSE 2008, physical inactivity levels amongst women in Tower Hamlets are not significantly different (68% and 71% respectively). In contrast however, it appears that men in Tower Hamlets have higher levels of physical inactivity than nationally (68% and 62% respectively).

Similarly, there was no evidence to show any statistically significant differences in physical activity levels between ethnic groups, or between genders within ethnic groups.

Those over 65 years were half as likely to meet the minimum physical activity guidelines than younger groups, as shown in Figure 9.

Wider determinants

Physical inactivity was more common in areas of higher deprivation. 30% of residents in the most deprived areas reported not being physically active at least once per week, compared to 22% in the least deprived areas. There was strong evidence that not being in Employment, Education or Training (NEET status) was significantly associated with higher levels of physical inactivity. 39% of those with NEET status were active less than once per week, compared to 18% of those employment, education or training. This may be addressed by targeting advice and opportunities for physical activity at those with NEET status.

Similarly, residents living in social housing were more likely to be physically inactive than those living in the private housing sector (31% vs. 20% were active less than once per week). This makes a case for targeting measures to increase physical activity in and around social housing settings and in partnerships with housing associations.

Residents without educational qualifications were more likely to be physically inactive. 40% of those without education reported being physically active less than once per week, compared to 21% of those with qualifications.

Poor English literacy (amongst residents for whom English is a second language) was also strongly associated with physical inactivity. 41% of those with poor English literacy were physically active less than once per week, compared to 24% of those with good English literacy.

Similarly, residents who reported that they had poor fluency speaking English were twice as likely to be physically inactive than those who spoke English well (39% vs. 23% reported being active less than once per week). Respondents who had moved to the area in the previous year were less likely to be physically inactive than those who had lived in Tower Hamlets for longer. 20% of 'migrants' reported inadequate physical activity compared to 27% of other residents. Therefore, whilst smoking and alcohol use is higher in this group, physical activity would appear to be less of an issue.

Health and physical activity

People with a long term condition, disability or infirmity were significantly more likely to be physically inactive than those without physical health problems. 47% reported that they were active less than once per week, compared to 20% of other residents. This is important because in addition to the general benefits of exercise, appropriate physical activity can improve or minimise the impact of many physical health issues. This highlights the importance of integrating physical activity into treatment pathways

Poor mental well-being was significantly associated with low levels of physical activity, even after controlling for age, gender and ethnicity. Respondents who were physically inactive scored significantly lower on the mental well-being scale than those who were physically inactive (51.8 compared to 53.9). This finding supports the need for physical activity interventions amongst those with poor mental health.

Wider determinants related to physical inactivity:

- High area-level deprivation
- Unemployment
- Living in social housing
- Poor education
- Poor English literacy and fluency
- Living in Tower Hamlets for at least a year

Findings on diet

What is 5-a-day?

The introduction of the '5 a day' programme in July 2000 was one of the government's key strategies aimed at preventative health behaviour. The principal objective of the '5 a day' initiative is to increase consumption levels of a variety of different fruits and vegetables to at least five portions (400g) per day. This is in accordance with the dietary recommendations of the World Health Organisation (WHO).

Adequate fruit and vegetable consumption brings substantial and broad-ranging health benefits by reducing the risk of heart disease, stroke, bowel and other cancers, Type II diabetes and obesity.

Prevalence

88% or respondents reported that they did not meet the 5-a-day target compared to 70% nationally (2008 Health Survey of England)

Demography

Men were more likely to eat an inadequate amount of fruit and vegetables than women, which reflects a national trend (HSE 2008). In Tower Hamlets, 92% of men did not reach the 5-a-day target, and 83% of women. This is significantly worse than the national figures – 78% for men and 69% for women.

Whilst age was not associated with fruit and vegetable consumption amongst men, older women were more likely to eat fruit and vegetables than younger women (Fig 10). This may reflect a fall in skills and knowledge about healthy eating in the younger generation.

There were significant and substantial differences in patterns of fruit and vegetables consumption by ethnicity as shown in Figure 11. Only 2% of Asian men, 3% of Black men and 12% of White men reported eating fivea-day. The Asian population was the least likely to reach the 5-a-day target. This is similar to The Health Survey for England 2004 minority ethnic booster survey, which noted that Bangladeshis had the lowest fruit and vegetable consumption of all ethnic minority groups.



Headline findings on diet

Across the borough, adequate fruit and vegetable consumption is low compared to the national average

Men are less likely to adequate levels of fruit and vegetables compared to women

Asian and Black populations have particularly low consumption.

Residents who eat at least 5-a-day are more likely to live in a less deprived area, to have higher levels of educational qualification and to be employed.

Wider determinants

There was a strong relationship between high levels of deprivation and low consumption of fruit and vegetables. 93% of those in the most deprived quintile reported eating fewer than five-a-day compared to 76% in the least deprived quintile.

Low educational attainment was significantly associated with inadequate consumption of five a day. 91% of those with no qualifications did not meet the 5-a-day target, compared to 86% of those with GCSEs, equivalents or higher qualifications. Similarly, a significantly higher proportion of those who had poor English literacy (94%) consumed fewer than five-a-day compared to those with good English reading skills (87%). This highlights the importance of communicating health promotion messages through media other than the written word.

Fruit and vegetable consumption was lower amongst those who were Not in Education, Employment or Training (NEET) than other residents (90% of those with NEET status reported not eating adequate amounts of fruit and vegetables, compared to 86% of non-NEET status).



There were significant associations between housing and inadequate consumption of fruit and vegetables. People living in social housing were twice as likely not to meet the 5-a-day target as people who owned or rented in the private sector (9% vs. 17%), even after controlling for age, gender and ethnic group.

There was no relationship seen between diet and migration into Tower Hamlets.

Health and diet

There was no evidence of a difference in consumption of fruit and vegetables between people with and without long term conditions, disabilities or infirmities. However, there was a weak association between people with lower mental health scores and not meeting the 5-a-day target (Mean mental health score 52.3 vs. 53.7).

Wider determinants related to poor diet:

- High area-level deprivation
- Poor education
- Poor literacy
- Unemployment
- Living in social housing

Findings on combined lifestyles analysis

Rationale

There is good evidence that behavioural factors influence health, but their combined impact on the general population is less well documented. The EPIC Norfolk study looked at four health behaviours in a UK population and found that combination of these behaviours could predict a 4-fold difference in total mortality in men and women¹. These health behaviours are:

- Not smoking
- Moderate alcohol consumption
- Eating five portions of fruit and vegetables per day
- Achieving at least 30 minutes of moderate physical activity on five days each week.

Our survey was designed to enable analysis of the extent to which individuals engaged in one or more of the healthy or unhealthy behaviours outlined in the previous sections. The headlines of this analysis are presented here.

Khaw et al, Combined Impact of Health Behaviours and Mortality in men and women: The EPIC-Norfold Prospective Populatiom Study PLoS Med 5 (1)

Findings

Figures 12 shows the main findings of this analysis. Overall, 40% of the population engaged in one or less of the healthy behaviours discussed previously (i.e. not smoking, moderate or no alcohol intake, physical activity five times a week and five fruit and vegetables a day).

A significantly higher proportion of females adopted three healthy lifestyles than men (47% compared to 35%). This may reflect the high proportion of Bangladeshi women who neither smoke nor consume alcohol. There was no significant difference in combined health behaviours between areas within Tower Hamlets (LAPs), but some seen for individual health behaviours as described in the later LAP analysis section.

Figure 12 Number of healthy behaviours adopted by Tower Hamlets residents Source: Tower Hamlets Adult Health & Lifestyle Survey 2009



Findings of Local Area Partnership (LAP) analysis

The survey was used to assess whether there were major differences between areas of Tower Hamlets. Tower Hamlets is divided into eight areas called Local Area Partnerships (LAPs – see chapter 1 for more information).

Table 2 compares the findings on health behaviours in the demographic and health in each LAP, compared to the borough average. Colours indicate whether there is evidence of a difference between the borough and LAP values.

The main findings relate to the variation of hazardous or harmful drinking across the Borough associated with the proportion of Bangladeshi residents in the LAP and the significantly lower consumption of 5 a day in LAPs 3 and 6.



Table 2 Health behaviour by LAPs

Source: Tower Hamlets Adult Health & Lifestyle Survey 2009

	Smoking prevalence	Do not meet minimum physical activity levels	Harmful or hazardous patterns of alcohol use	Do not eat 5-a-day	None or only one healthy lifestyle behaviours
	%	%	%	%	%
LAP 1	27%	69%	23%	91%	41%
LAP 2	27%	63%	21%	91%	36%
LAP 3	31%	68%	16%	93%	40%
LAP 4	23%	70%	27%	79%	42%
LAP 5	29%	73%	26%	87%	41%
LAP 6	27%	70%	12%	94%	39%
LAP 7	30%	69%	19%	84%	46%
LAP 8	24%	64%	26%	83%	40%
All	27%	68%	22%	88%	41%

Discussion

Key findings

The survey provided valuable information about four key health behaviours within the borough and highlighted groups of residents who were more likely to engage in behaviours that present a threat to their health (table 3):

• Smoking: Stopping or refraining from smoking

- Tower Hamlets has higher than average smoking prevalence
- Smoking is most common amongst men, particularly Asian men.
- Smoking was strongly associated with low socio-economic status.
- Poor mental and long-term physical health was more common amongst smokers.
- Alcohol: Consuming moderate amounts of alcohol
 - Tower Hamlets has lower than average alcohol consumption, but twice the national average of harmful or hazardous drinking in drinkers
 - Alcohol use and harmful/hazardous use was more common amongst the white population. Young, white men were at particularly high risk.
 - Alcohol use was associated with greater affluence — it was more common in less deprived areas, amongst the better educated and people living in private sector homes (even when controlling for ethnicity)
- Physical activity: Reaching 30 minutes moderate exercise on five days each week
 - Physical activity levels are low but similar to national averages
 - There were no differences between genders or ethnic groups, although older people were less active
 - Physical inactivity was strongly associated with low socioeconomic status.

- Those with poor physical and mental health were more likely to report low physical activity levels
- Diet: Achieving the recommended 5 portions of fruit and vegetables per day
 - Only 12% of residents ate 5-a-day
 - Women and the white population were more likely to reach this target
 - Inadequate fruit and vegetable consumption was strongly associated with low socioeconomic status
 - Poorer mental health was associated with lower consumption of 5– a– day

In general, the findings confirm other evidence of a higher prevalence of risk factors in men (apart from physical activity) and this is consistent with significantly lower life expectancy in males compared to females (5 years lower in Tower Hamlets).

Survey limitations

The survey was designed to be able to detect differences between the white and Bangladeshi populations, but not between smaller population groups, which limited the comparisons that could be made.

All of the information obtained was self-reported which may have led to some inaccuracies, either through lack of knowledge or as respondents might have preferred not to discuss the truth. Variables such as smoking, alcohol use and body mass index were particularly vulnerable to these biases, and as such should be interpreted with caution.

What does this mean for public health?

In general, Tower Hamlets residents have a lower prevalence of healthy behaviours than elsewhere: smoking use is high, harmful or hazardous drinking is high in the White population, physical activity is uniformly low and the majority of people eat a insufficient amount of fruit and vegetables. A substantial impact on Tower Hamlet's low life expectancy could be made by tackling these major four health behaviours, with a potential four-fold reduction in mortality offered by the EPIC study if all four behaviours are addressed.

The research is largely congruent with our existing understanding and with the findings of the Marmot Review.

Implications

The analysis described in this chapter only covers the main headlines from the survey (summarised in Table 3). There remains work to explore issues and questions that emerged from the analysis. In addition, we will be linking the database with a number of other databases to give us further insight into how healthy lifestyles in Tower Hamlets is linked to mortality, hospital admissions, primary care disease registers and social marketing segmentation data. This will enable us to continue to have the richest possible insight into the healthy lifestyles in our population and to ensure that our strategies are having the greatest impact on improving health and wellbeing in Tower Hamlets.

Recommendations

 The relativey high prevalence of unhealthy lifestyles behaviours in the Tower Hamlets adult popoulation confirms the need to maintain momentum across the partnership of Tobacco Control, 'Healthy Weight, Healthy Lives in Tower Hamlets', 'Healthy Borough' and Alcohol strategies

- Borough-wide approaches to improve healthy lifestyles need to be balanced with targeted approaches addressing specific population segments and localities within the Borough to address health inequalities
- Locality and LAP levels structures (e.g. primary care networks, polysystem, LAP steering groups) need to work at very local level (e.g. estate level) to address those within their population with particularly high prevalence of unhealthy behaviours
- Although in general, the Tobacco Control Strategy has targeted the at-risk groups identified in the Survey; two groups that need additional focus are older Bangladeshi men and white females
- Lower levels of physical activity across the population highlight the need to sustain current

Table 3 - The findings of the Adult Healthy and Lifestyles Survey emphasise the need to link healthy lifestyle services with services addressing wider determinants of health, integrate them into clinical and social care pathways and target by population segment

Associations	Smoking prevalence	Physical inactivity	Poor diet	Risky drinking
Gender	† in Males	No	† in Males	† in Males
Ethnicity	† in Asian males	No	1 in Asian and Black populations	1 in White population
Age	† in young Black population	1 in older people	1 in younger women vs. older women	1 in young, especially young white men
Deprivation	1 if more deprived	1 if more deprived	† if more deprived	1 if more deprived
Education	1 if lower attainment	1 if lower attainment	1 if lower attainment	1 if lower attainment
Employment	1 if unemployed	1 if unemployed	† if unemployed	1 if unemployed
Poor English literacy	1 if poorer English literacy	1 if poorer English literacy	1 if poorer English literacy	No
Housing	† if social housing	1 if social housing	† if social housing	1 if social housing
Long term conditions	1 if LTC	1 if LTC	No	f if LTC in White population
Mental health	1 if poorer MH	1 if poorer MH	1 if poorer MH	No

Source: Tower Hamlets Adult Health & Lifestyle Survey 2009



work (Healthy Borough, Local Development Framework) to design the built environment to make it easier to integrate everyday physical activity into daily life in Tower Hamlets

- Although physical activity is integral to the long term conditions pathways we have developed, we need to monitor the extent to which physical activity levels are measured and track improvements
- The substantially lower levels of healthy eating (as measured by five-a-day) in the population compared to elsewhere means that we need ensure that we are making the best possible use of existing levers to increase access, awareness and availability of healthy foods in the Borough and to influence healthy eating behaviours
- In general, there is a need to ensure that our strategies reflect the higher prevalence of risk factors in men (particularly diet and smoking) and that the services to support healthy lifestyles actively seek to recruit men (existing service data shows underrepresentation of this group)
- Healthy lifestyles strategies need to actively incorporate integrating work with adult education programmes, programmes to increase English literacy (e.g. ESOL), employment programmes and social housing services
- The high prevalence of unhealthy lifestyle behaviours in people with poorer mental wellbeing means that we need to ensure that promotion of healthy lifestyles is build into mental health pathways and that the impact of this is monitored to the same extent as clinical interventions

3 Cancer in Tower Hamlets

Introduction

Cancer is an important local health priority. Tower Hamlets has amongst the highest mortality rates from cancer in the country and cancer is the second highest cause of premature death in the borough.

The financial impacts of cancer on the health service and society are substantial. It has been calculated that for the UK, the cost of cancer was £18 billion in 2008, and that these costs will increase to £25 billion by $2020^{(1)}$.

Between 2006 and 2008, 988 Tower Hamlets residents died from cancer; of these more than half (53%; 527 people) died prematurely, before the age of 75 years⁽²⁾. In 2008, there were 630 new cases of cancer and 3,515 people in Tower Hamlets were living with cancer⁽³⁾.

The four most common cancers in the UK and in Tower Hamlets are lung, breast, colorectal (bowel) and prostate cancers. Together these account for over half (54%) of all new cases and more than 47% of cancer deaths.

Table 4 shows that the incidence (new cases) of breast and colorectal cancers in Tower Hamlets was not significantly higher than London and/or England, and for prostate cancer was significantly lower. Importantly, survival rates were lower leading to relatively higher mortality rates. However for lung cancer, although survival rates are similar to London and England, higher incidence (reflecting higher smoking prevalence) translates into very high mortality. Lung cancer is one of the key drivers for the high overall cancer mortality rates in Tower Hamlets.



Table 4 Cancer in Tower Hamlets: comparison with London and England



Key Priorities

Our vision for Tower Hamlets is to reduce overall cancer incidence and premature mortality from cancer; and to reduce the inequalities in both cancer incidence and premature mortality by:

- Reducing the number of people who develop cancer through prevention programmes that address both individual lifestyles and the environment in which people live and work, particularly smoking cessation and tobacco control.
- Improving cancer survival through improved early detection of cancer. This will include increasing the uptake of screening, raising awareness of cancer symptoms and the importance of seeking medical advice early, and removing delays in referral for specialist diagnosis and treatment.
- Ensuring that people with cancer have access to high quality services as defined by the National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG) and that they receive optimal treatment for their condition.

Cancer Prevention

The cornerstones of cancer prevention are the four key lifestyle behaviours explored in the Health and Lifestyles Survey — smoking, alcohol use, physical activity and diet. At least half of all cancers could be prevented if people made changes to their lifestyle, particularly stopping smoking, reducing alcohol intake, increasing their physical activity, eating more healthily and maintaining a healthy bodyweight as well as avoiding excessive sun exposure⁽⁴⁾ (table 5)

Addressing these behaviours will prevent a large proportion of the borough's high cancer burden. The Health and Lifestyles Survey was commissioned to understand the patterns of lifestyles amongst residents, so our work can be most effectively directed at high risk groups.

Cigarette smoking has been identified as the single most important cause of preventable death in the UK. More than a quarter of all deaths from cancer are linked to tobacco, including around 90% of cases of lung cancer in men and 83% of cases in women.

Lung cancer is the largest single cause of cancer deaths in Tower Hamlets, which has the highest mortality from lung cancer in London. There were 39.5 deaths per 100,000 of

Risk factor	Lung Cancer	Breast Cancer	Colorectal (Bowel) Cancer	Prostate Cancer	Cervical Cancer	Stomach Cancer
Smoking	\checkmark		\checkmark		\checkmark	\checkmark
Alcohol	(√)	\checkmark	\checkmark			\checkmark
Physical activity	\checkmark	\checkmark	\checkmark	(√)		
Diet and nutrition	(√)	\checkmark	\checkmark	(~)		\checkmark
Obesity		\checkmark	\checkmark	(√)		\checkmark
Infection					HPV*	H. pylori**

Table 5 Risk factors for common cancers

*Human Papilloma Virus

**Helicobacter Pylori

the population, compared to 25.6 in London and 26.5 in England and Wales, in people aged under 75 years (DSR, 2006–08). This is driven by a higher than average smoking prevalence -27% of Tower Hamlets residents are smokers, compared to 21% nationally.

The importance of lifestyle as a determinant of the health of Tower Hamlets residents is reflected in the broad portfolio of public health work undertaken in the borough. This includes significant investments in smoking cessation, the "Healthy Weight, Healthy Lives" strategy to address obesity (encompassing diet and physical activity), and broad partnership working around alcohol use.

TheTower Hamlets model of delivering public health through our Local Area Partnerships (LAPs) and corresponding Primary Care Networks allows strong partnership working to signpost and support people to make changes to their lifestyles. This is led by the Healthy Lifestyle Programme Managers and includes commissioning a substantial Health Trainer programme. Other local cancer prevention successes in 2009/10 include:

- 2400 people successfully quit smoking with support of the Tower Hamlets Tobacco Control programme. Rates continue to improve and exceed targets.
- Cycling to school increased by 5–14% through the 'Bike-It project'
- 81% of schools achieved Healthy School status.
- 35 pupil-led projects to increase physical activity and healthy eating choices.
- 97% of girls aged 13–14 were immunised against HPV. Tower Hamlets had the highest uptake of HPV vaccination in England.

Cancer Incidence

The incidence of cancer (new cases) in Tower Hamlets is slightly higher than that of London and England (fig 13). The gap between Tower Hamlets and national rates appears to be narrowing, due mainly to decreasing incidence of cancer in Tower Hamlets males. Between 2004 and 2006, there were 379 new cases of cancer diagnosed per 100,000 population in Tower Hamlets compared to 375 nationally (DSR). The higher incidence of cancer in men, particularly lung cancer in Tower Hamlets is the main reason for this gap. The incidence of all cancers in males in Tower Hamlets was 416 per 100,000 population compared to 387 in London and 408 in nationally. For women, the incidence was 350 per 100,000 in Tower Hamlets, compared with 320 for London and 353 nationally.

Over the past 10 years there have been between 600 and 656 new cases of cancer each year, apart from in 2004 (568 cases). The four commonest cancers (lung, breast, colon and prostate cancer) accounted for just over half of all cancer diagnosed between 2004 and 2006 (figure 14).

Source: National Centre for Health Outcomes Development (NCHOD)



Figure 13

Incidence from all Cancers 1993-2008, all ages (3 year rolling average 1993-1995 to 2004-06) Source: NCHOD

> Figure 14: Cancer diagnoses in Tower Hamlets All ages, 2004-06 pooled data, numbers Source: NCHOD



What is cancer incidence?

Incidence rates describe the number of new diagnoses of cancer that are made per year per 100,000 people. To make meaningful comparisons between areas, the figures are adjusted to account for different aged populations. These are called Directly Standardised Rates (DSR).



Figure 15: Lung cancer incidence, all ages Source: NCHOD







Figure 17: Colorectal cancer incidence, all ages Source: NCHOD

Lung cancer

Tower Hamlets has a higher incidence of lung cancer than both London and England & Wales. Both nationally and locally, incidence has been falling over the past two decades, but the gap remains similar. Incidence in men is higher than in women, although the gap has started to narrow due to changes in smoking behaviour. Tower Hamlets incidence rates in both males and females are higher than those of London and England & Wales, although incidence in males in Tower Hamlets has been declining slightly faster than nationally (figure 15).

Breast cancer

Tower Hamlets incidence of breast cancer is lower than national and London rates, which reflecting comparatively larger family sizes and the earlier age at which women have their first child in the borough (figure 16). These are protective factors for breast cancer.

Colorectal (bowel) cancer

The incidence of colorectal cancer in Tower Hamlets has risen over the past decade and is similar to that of London (figure 17).

Prostate cancer

Both national and local incidence of prostate cancer increased between 1993 and 2002, although this increase may be due partly to better detection through PSA testing in some areas and not a true reflection of increased incidence. Tower Hamlets incidence is lower than the London and England rates (figure 18).



Figure 18: Prostate cancer incidence, all ages Source: NCHOD

Cervical cancer

Nationally, the incidence of cervical cancer fell by 42% between 1988 and 1997, closely matching the delivery of the cervical screening programme. Today about 1% of all cancers are cervical, a reflection of the success of the cervical screening programme. The incidence of cervical cancer in Tower Hamlets is similar to the national and London picture, and any differences should be interpreted with caution as the actual numbers are small. In 2006 there were 9 cases of cervical cancer in Tower Hamlets (figure 19).

Stomach cancer

Cancer of the stomach occurs mainly in older people, with less than 8% of cases diagnosed before the age of 55. Rates increase steeply after age 60 years reaching a rate of around 140 per 100,000 population in men aged 85 and over. Data indicates that Tower Hamlets has a higher incidence of stomach cancer than London, but a similar level to the UK, with 34 cases diagnosed between 2006 and 2008 (figure 20).



Figure 19: Cervical cancer incidence, all ages Source: NCHOD



Figure 20: Stomach cancer incidence, all ages Source: NCHOD

Cancer mortality

Although nationally, mortality rates from cancer have been falling over the last two decades, cancer is still responsible for one in four of all deaths in the UK (figure 21). Between 2006 and 2008, 988 people in Tower Hamlets died from cancer; of these more than half (53%, 527 people) died prematurely (<75) (figures 22 and 23).

There are marked inequalities in mortality from cancer in Tower Hamlets compared with both London and national rates. Premature mortality rates from cancer are higher than both London and England. Although rates are falling, Tower Hamlets' decline has slowed since 1998. The borough is not on course to meet the inequalities target of reducing the gap in cancer mortality in people aged less than 75 years by at least 6% between the most deprived areas and the national average. Between 2005 and 2007, cancer mortality in Tower Hamlets in people under 75 years was 145 per 100,000 of the population (DSR), compared to 110 in London and 115 in England.

What is cancer mortality?

Cancer mortality rates measure the number of deaths due to cancer per 100,000 in a given time period. Like incidence rates, mortality rates can be Directly Age Standardised (DSR) to account for different population structures. Premature deaths (defined as those before 75 years) are used in national targets to drive improvements in prevention and cancer care.



Figure 21: Mortality from common cancers in Tower Hamlets, London and England & Wales 1994 – 2008, all ages Source: NCHOD



Figure 22: Cancer mortality in Tower Hamlets, under 75 years Source: NCHOD



Figure 23: Cancer mortality in Tower Hamlets, all ages Source: NCHOD



Figure: 24(above): Lung cancer mortality, under 75 years

Figure: 25(below): Lung cancer mortality, all ages Source: NCHOD



Lung cancer

In the UK, more than 35,000 people died from lung cancer in 2008, of which more than 75% were aged over 65 years (figures 24 and 25). Amongst Tower Hamlets residents, lung cancer is the second highest cause of death. Premature deaths from lung cancer have been decreasing in Tower Hamlets since 1994, but mortality rates remain higher than national rates. For men, there has been an overall decline in line with national trends, although the gap remains the same. For women there has been a slight increase.



Figure 26 (above): Breast cancer mortality, all ages

Figure 27 (below): Breast cancer mortality, 50-69 years Source: NCHOD



Breast cancer

Nationally, around 12,000 women and 70 men die from breast cancer each year. Earlier detection through screening and improved treatment have contributed to a decline in mortality from breast cancer both nationally and locally over the past 15 years. Mortality from breast cancer in Tower Hamlets is slightly (but non-significantly) lower than nationally. Between 2006–08, there were 52 deaths from breast cancer in Tower Hamlets, of which 56% (29) were premature deaths in women under 75 years. While rates for Tower Hamlets appear to be lower than other areas, this should be interpreted with caution, as small numbers cause large fluctuations that make it difficult to determine any real trend (figures 26 and 27).





Figure 29 (right): Prostate cancer mortality, all ages Source: NCHOD



Colorectal (bowel) cancer

National mortality rates for colorectal cancer have declined since 1995. Tower Hamlets mortality rates for people both under 75 years and all ages is higher than London and England rates. As with breast cancer, this should be interpreted with caution, as small numbers cause large fluctuations that make it difficult to determine trends. Colorectal cancer was the second most common cause of cancer death in Tower Hamlets, accounting for 91 (9%) of all cancer deaths between 2006 and 2008; almost 53% (48) of these were in people under 75 years old (figure 28).

Prostate cancer

Mortality from prostate cancer has declined since 1994 and has been consistently lower in Tower Hamlets than London and England. Between 2006 and 2008, there were 12 deaths from prostate cancer in Tower Hamlets (figure 29).



Cervical cancer

Nationally, around 940 women die from cervical cancer each year. It is rare for very young women to die from cervical cancer; almost 80% of deaths occur in women aged 45 years and over. Nationally, mortality rates between 2006-8 (2.35 per 100,000 females) were nearly 70% lower than they were 30 years earlier (7.1 per 100,000 females in 1979) following the introduction of the national screening programme. Mortality in Tower Hamlets is higher than both London and England at 3.54 per 100,000 population although actual numbers are relatively low, with 8 deaths between 2006 and 2008. Again, caution should be exercised when interpreting very low numbers (figure 30).

6.75

4.00

994-96

79-292

86-9661

1997-99

_

00-8661

E & W

Stomach cancer

10-6661

2000-02

London

Each year more than 5,200 people die from stomach cancer in the UK. Stomach cancer accounts for around 3% of all cancer deaths. Mortality rates in the UK have fallen by around 70% over the last 30 years. Tower Hamlets stomach cancer mortality rate (9.1 per 100,000 population, DSR in 2006 - 8)) remains higher than the national rate of 5.6 per 100,000 (figure 31). Stomach cancer was responsible for 21 deaths in Tower Hamlets between 2006 – 2008, making it the 4th largest cause of cancer mortality in Tower Hamlets. There appears to be a particularly high number of deaths from stomach cancer in younger people in Tower Hamlets.

2002-04

Tower Hamlets

2001-03

_

2004-06

2003-05

2006-08

2005-07



Figure 32: 5 year survival from common cancers, 1998-2002 Source: CCCU (Cancer Commissioning Care Unit)



Figure 33: One year survival from common cancers, 2002-2006 Source: CCCU



Figure 34: One year survival trend from common cancers, 1994-2006 Source: CCCU

Cancer Survival

Despite reductions in cancer mortality and increases in survival, the UK has poorer cancer survival than many comparable European countries.

Cancer survival at one year in Tower Hamlets is amongst the lowest in England (figure 33). 1-year survival from all cancers in Tower Hamlets was 58.7%, compared to 65.0% in England (2006).

There is evidence that late diagnosis is driven a combination of late presentation, delayed referral, poor screening uptake and the significant effect of deprivation on survival. Patients in areas of higher deprivation are more likely to be admitted as emergency cases and are less likely to receive preferred treatments for their disease⁽⁵⁾ – indicating that their disease is already advanced when it is diagnosed.

It has been estimated that 1,000 fewer people in London would die from cancer each year (around 20 to 25 people in Tower Hamlets) if one-year survival was as good as the best in England. Furthermore, if cancer services and survival were to be improved to be amongst the best in Europe, 11,000 lives could be saved each year nationally⁽⁶⁾.

The National Cancer Plan (2000)⁽⁷⁾ aimed to increase cancer survival by improving the quality of treatment and cancer care. The Cancer Reform Strategy (2007)⁽⁸⁾ and the Case for Change Healthcare for London review of cancer services⁽⁹⁾ recognised that to achieve further improvement in cancer survival, focus needs to move to earlier diagnosis of cancer. Treatment is more effective and survival better if cancer is treated in the early stages.

What is cancer survival?

Cancer survival is measured by the percentage of people who are alive at either one or five years after they were diagnosed with cancer. One-year survival is strongly influenced by how advanced the cancer is at diagnosis, whereas five-year survival can reflect the quality of care received by patients.

Survival at one year is therefore an increasingly important measure and is used as a proxy for early diagnosis.

Lung cancer

Lung cancer has one of the lowest survival outcomes of any cancer. This is partly due to rapid progression and late stage at diagnosis. Less than 10% of people with lung cancer survive for 5 years in England and Wales (figure 32), and survival rates can be twice as high in the best performing countries in Europe and in the United States⁽¹⁰⁾.

One-year survival in Tower Hamlets was slightly better than England, but this has declined and is now similar to the national rate (figure 34). Between 2002 and 2006, 29.1% of people with lung cancer in Tower Hamlets survived for at least one year after diagnosis, similar to 29.8% in London and 28.3% in England (figure 33).

In patients diagnosed early, surgery can improve survival. However more than two-thirds of lung cancers are diagnosed at a late stage and so survival rates for these patients are lower. Evidence shows that people from more socially deprived areas are less likely to receive surgical interventions for lung cancer and have worse survival compared to people in more affluent groups. The reasons for this have yet to be explained, and may for example, be related to co-morbidities preventing more radical treatment as well as later presentation⁽¹¹⁾.

Earlier diagnosis depends on recognition of symptoms, early presentation and prompt referral. Recent research into Tower Hamlets residents' awareness of cancer symptoms found that only 8% of people mentioned 'cough' as a symptom of lung cancer⁽¹²⁾. Cough and hoarseness were the symptoms about which people were most likely to

delay seeking medical advice (15% waiting a month or more) compared to other possible cancer symptoms such as weight loss, lumps or bleeding.

Although studies are exploring screening for lung cancer, there is insufficient evidence to support its implementation. Across inner north-east London, a targeted programme is being developed to raise public awareness of the importance of reporting cough and other potential cancer symptoms early. This will be combined with support for GPs to refer at-risk patients promptly. Based on a successful "push-pull" model in Doncaster, it has been estimated that the lives of up to 6 people with lung cancer each year could be saved in Tower Hamlets through this programme.

Breast cancer

National and local breast cancer survival rates are improving. However survival is significantly higher amongst women from affluent areas compared to women living in deprived areas. This is reflected in Tower Hamlets, where despite lower incidence, survival continues to be worse than for London and England.

As with all cancers, later diagnosis is a major factor in poor survival, with one-year survival being a good proxy measure for early diagnosis, and the main predictor of five-year survival. In 2009, Tower Hamlets had the lowest one-year survival rate for breast cancer in England. Between 2002 and 2006, 89.4% women with breast cancer in Tower Hamlets were alive one year after diagnosis compared with 93.7% in London and 95% in England (figure 33). A "one-stop" assessment clinic for breast symptoms commenced at Barts and the London NHS Trust in January 2010, and 100% of Tower Hamlets women with breast symptoms referred by their GP are now assessed within 14 days of referral. Early indications from more recent data have shown that survival in Tower Hamlets has improved.

Recent work in North East London has identified that breast cancer survival is a key issue, where improvements have not kept pace with the rest of the country⁽¹³⁾. Poor awareness of symptoms and barriers to early presentation contribute to this. An audit of the pathways of women who have died within one year is being set up to better understand and address inequalities in survival.

Screening for breast cancer has successfully reduced mortality and improved survival. Women whose breast cancer is detected through screening have a significantly better one-year survival (95%) than those diagnosed outside the screening programme (77%). Currently 37% of breast cancer diagnoses in London are made through the screening programme. The programme will be extended to women aged 47 to 73 years over the next year, and services are being developed to offer screening to women at risk of familial breast cancer in line with NICE guidance.

Colorectal (bowel) cancer

One-year survival for colorectal cancer in Tower Hamlets is similar to the average for London and poorer than the national rate. Between 2002 and 2006, 70% of people with bowel cancer in Tower Hamlets survived for at least one year after diagnosis, compared to 69.5% in London and 72.4% in England (figure 33).

Nationally, five-year relative survival rates for both male and female colorectal cancer improved two-fold between the early 1970s and mid 2000s as a result of earlier diagnosis and better treatment, but there is still scope for further progress, particularly in increasing the uptake of screening.



Screening for pre-cancerous changes can prevent colorectal cancer⁽¹⁴⁾. Most cases develop slowly over a number of years as benign adenomas (polyps) that transform into malignant adenocarcinomas. Early detection of asymptomatic conditions enables either removal of polyps or treatment of cancer at an early stage when survival rates are high. Bowel cancer screening for men and women aged 60 -69 years has been introduced nationally through a phased programme completed early in 2010, so that health promotion and subsequent public awareness has been limited and localised. During 2010/11, the programme is due to be extended to people aged 70 - 74 years.

Prostate cancer

Survival for people with prostate cancer has been improving for the past 30 years. In England, one-year survival improved from around 65% for patients diagnosed between 1971 and 1975, to 94.3% for patients diagnosed between 2002 and 2006. The one-year survival rate in London during the same period was 92.3%, and was lower in Tower Hamlets at 90.3% (figure 33).

Cervical cancer

Nationally more than 80% of women diagnosed with cervical cancer between 2004 and 2006 survived their disease beyond one year after diagnosis. Five-year survival rates in Tower Hamlets for cervical cancer are slightly higher (65.5%) than for London (63.6%) and England (62.9%). This may reflect that Tower Hamlets has a younger population and younger women have a better survival rate than older women. This is at least partly because the disease in younger women tends to be diagnosed at an earlier stage.

Cervical screening is offered to all women aged 25 to 69 every 3 to 5 years depending on their age. Successful screening prevents cancer developing by identifying and treating early changes to cells. It is estimated that the programme prevents about 3,900 cases of cervical cancer and saves around 1,300 lives in the UK each year.

Improving cancer survival

Increasing the uptake of cancer screening

National programmes for breast, bowel and cervical cancer screening are in place.

Survival from cancer is improved when it is detected early by

- increasing the uptake of screening
- increasing awareness of cancer and early presentation
- reducing delays in referral

Breast cancer screening

Breast screening coverage rates in Tower Hamlets (the proportion of eligible women screened in the last 3 years) have been consistently lower than both London and national rates. There was a 10% increase in coverage (to 63.5% in March 2009) and further improvements in 2010, following investment in a range of evidence-based interventions and implementation of social marketing research recommendations. These include improving accessibility and responsiveness of the screening process, raising awareness and following up women who do not attend. The target is to achieve the national minimum standard coverage for women aged 53 to 70 years of 75%



by March 2015. We are evaluating the impact of different interventions that have contributed to improving the uptake and coverage of breast cancer screening, to inform future investment.

Bowel cancer screening

Tower Hamlets uptake of bowel screening is well below the national minimum standard of 60%. Recent local research showed that just 17% of 421 people surveyed were aware of the bowel cancer screening programme (34% amongst the target population of 60 - 69 year olds)⁽¹⁵⁾. We are testing and evaluating different approaches to increasing the uptake of bowel cancer screening, particularly amongst people from black and minority ethnic groups and people living in areas of higher deprivation. Evidence shows that 'physician endorsement' is a key factor in participation, and interventions which involve GPs are therefore crucial in improving local uptake. A bowel cancer screening health promotion specialist is working with GPs, other primary care services, such as pharmacists, and community groups to raise public awareness and increase participation in the programme.

Cervical cancer screening

Cervical screening coverage in Tower Hamlets was 70.4% in March 2010, below the national standard of 80%. Coverage was lowest amongst younger women aged 25 - 49 years (63%) compared to women aged 50 - 64 years (77.2%). Our target is to achieve overall coverage of 80% by 2014, with a steeper increase in the younger age group, using recommendations of local social marketing research. This includes specifically targeting younger women, working with primary care to follow up women who do not respond to the invitation for their cervical screening appointment and increasing opportunistic screening.

Raising public and professional awareness about cancer symptoms and promoting early presentation, particularly amongst people who are most likely to delay seeking advice

People in Tower Hamlets have a low awareness of cancer signs and symptoms

Recent research using a validated Cancer Awareness Measure (CAM) undertaken amongst 3,500 people in the seven North East London PCTs showed low public awareness of cancer symptoms and lifestyle risk factors, and identified barriers to seeking advice⁽¹⁶⁾.

Only 42% people recalled that a lump or swelling might be cancer, and less than 30% people recalled any other signs. People from Black and Ethnic Minority (BME) groups, older people and those in the most deprived areas, had very low recognition of symptoms. Symptoms of the most common cancers (lung, breast, bowel and bowel) were mentioned by less than 10% of people. When people were asked if they could recognise symptoms from a list, results were better, but Bangladeshi people had amongst the lowest awareness; they recognised only 56% of warning signs compared with 74% recognised by people of white ethnicity.

Although a high proportion of people recognised smoking as a risk factor for cancer, there was less certainty, particularly amongst BME groups about whether lifestyle (diet, exercise, obesity and alcohol consumption) were risk factors. Overall, there was sizable underestimation of cancer incidence; 40% of respondents perceived their lifetime cancer risk as less than 1 in 20.

Reasons that stop people seeking help for their GP

Most people said they would seek a GP appointment within 2 weeks of a potentially serious symptom, but there were some delays in older people and in women seeking help. Perceived barriers were being too busy, difficulty making an appointment and for those in more deprived areas, worry about what the doctor might find. Women were more likely to be embarrassed or scared.

Opportunities for improvement

Recommendations include interventions aimed at improving awareness of cancer signs and of lifestyle risk factors, targeting women and people in more deprived areas. This should be through communication campaigns and primary care initiatives which empower people to increase awareness of symptoms and believe that their symptom is important. Specific work is needed to raise awareness of bowel cancer as a common cancer, and of the associated screening programme.

Reducing delays in primary and secondary care to ensure that people with cancer are diagnosed quickly and offered rapid access to the best available treatments

The urgent referral pathway is underused in Tower Hamlets

GPs are able to make urgent referrals to hospital for suspected cancer following NICE guidance for suspected cancer ⁽¹⁴⁾. These guidelines are currently being updated. Patients referred through this route will be seen within 14 days, and



these are referred to as 'two week wait referrals'. In England, the proportion of cancers diagnosed following urgent referral varies widely from 23% to 76% with an average of 45%. In 2008/9, 33% of breast cancer diagnoses in Tower Hamlets were made through urgent referral – the lowest in North East London; this increased to 49% during 2009/10, but remains lower than most other North East London PCTs (range 41.5% – 68.7%) ⁽¹⁸⁾. As a result, all patients with breast symptoms are now referred using the two-week wait route, which is significantly improving urgent referral rates.

Understanding delays to diagnosis

Tower Hamlets GPs recently participated in an audit of new cancer referrals to identify and address potential delays to early diagnosis in primary and secondary care. 168 cancer referrals made during 2009 of breast, bowel, lung and prostate cancers identified from hospital records were included (10 were from Tower Hamlets)⁽¹⁹⁾.

Breast cancer

Key findings showed that breast cancer patients seemed more likely to delay seeing their GP, but the majority (76%) were referred speedily through the urgent referral route and saw a specialist promptly. However there were a small number (18%) who repeatedly visited their GP and 8% waited more than 2 months before referral. The longest reported time from first presentation to being seen by a specialist was just over a year.

Bowel cancer

Bowel cancer patients were more likely than other patients to have presented more than once in primary care before referral and to have been referred via a routine referral. This may reflect the fact that symptoms of colorectal cancer are more diffuse than those for breast cancer.

Lung cancer

Although more than half of lung cancer patients first presented in primary care, nearly a third first presented in Accident and Emergency and a fifth were sent in as emergency referrals. This suggests that people do not recognise symptoms until they become severe, and this will impact on their chances of survival.

Prostate cancer

Prostate cancer patients were frequently diagnosed through PSA tests and were least likely to have advanced disease. However, overall waiting times for these patients seem to have been longer and less than half were seen by a specialist within one month of presentation.

A fifth of patients overall (and a third of lung cancer patients) had metastatic disease (secondary tumours) by the time that they were diagnosed. For 15% of patients, stage of disease was not recorded so this figure may be higher. Of those with metastatic disease, 40% had been to their GP at least twice before being referred, and 16% had had a routine referral, so it is likely that there were avoidable delays.

The presenting symptoms for these four cancers are mainly in line with referral guidelines. However a number of patients had presenting symptoms not in the guidelines for the specific cancer with which they were diagnosed, or rather vaguer than the guidelines. This validates GPs' concerns that the referral guidelines are not specific enough.

Ten per cent of patients in this audit waited longer than 2 months from the time that they first presented with symptoms to the time that they were referred. This suggests that some training in primary care would be beneficial. GPs felt that it would be helpful to have more rapid access to diagnostics, particularly for bowel cancer patients. This may help to reduce the number of patients who are referred as routine referrals and speed up the pathway for these patients.

The findings of this audit should be used as a baseline against which interventions to increase early diagnosis can be evaluated, and on which to base tailored education and updating for GPs about cancer treatments and outcomes, with emphasis on identifying and referring possible cancers urgently for assessment. There is also a need for new cancer referral guidelines to be disseminated once they are published.

Building a cancer intelligence infrastructure

Cancer intelligence that enables analysis of timely and detailed information is essential in helping to evaluate the effectiveness of initiatives to improve survival and to treat cancer effectively.

There are challenges to recording staging data overall in England and Wales. For example, between 1998 and 2007, only 13% Tower Hamlets lung cancer cases had the stage of cancer recorded⁽²⁰⁾.

Although detailed confidential records of all cancer diagnoses are maintained by hospital multi-disciplinary teams, records have mainly been used to report on waiting time and treatment targets, and in this respect have helped to ensure that urgent referrals are seen within 2 weeks and people diagnosed with cancer receive prompt assessment and treatment. However, clinical assessments of the stage of cancer at diagnosis are not uniformly or routinely available electronically for analysis, with only selected data being used. Work is underway to make this data available, in order to measure improvements in earlier presentation and diagnosis following interventions.

Treatment for cancer

Targets are set for cancer specialist services for waiting times for assessment and treatment, and for reconfiguration of services in line with Improving Outlines Guidance (IOGs). Progress against these targets is closely monitored by the Specialist Cancer Commissioner in the Inner North East London Sector Commissioning Unit working with the North East Cancer Network.

Treatment is most successful when cancer is detected early. There is evidence that despite the implementation of the Cancer Plan, social factors still strongly influence access to the provision of care for people with common cancers. People living in areas of higher deprivation, men and older people are less likely to receive preferred surgical treatments for lung, bowel and breast cancer⁽²¹⁾.

Research into pathways for local people with cancer, focusing on the commonest cancers, needs to identify inequalities in incidence, stage of diagnosis, treatment and survival, which will help to inform interventions to target inequalities and commissioning decisions, and to drive up the quality of performance.

Detailed analysis of data and pathways for different tumour sites needs to be undertaken, to ensure that budgets are allocated effectively, with most impact on outcomes for patients. To achieve the best possible outcomes, cancer patients should:

- have access to high quality services as defined by the National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG)
- receive optimal treatment for their condition

Living with cancer

The increasing prevalence of cancer in an ageing and growing population, combined with better treatment outcomes, means that many more people are living with and beyond cancer. In 2008 there were 2 million cancer survivors in the UK with an estimated increase of 3.2% every year. 39% of the cancer survivors were of working age and 60% are over 65 years old. The National Cancer Survivorship Initiative (a joint Department of Health and Macmillan Cancer Support initiative) seeks to address the lack of consistent assessment, care planning, information and support pathways



for cancer survivors, and to address the gaps in services providing supportive and rehabilitative interventions once patients' needs are identified⁽²²⁾.

Data from Thames Cancer Registry was used the estimate the number of cancer survivors living in Tower Hamlets at 3,515 in 2009 (table 6).

Consultation with cancer survivors in Tower Hamlets highlighted the need for psychological support, assistance in getting lifestyle back to normal after treatment and information on self monitoring, exercise, healthy eating and assistance with return to work. They also expressed the need for these services to be within their local community.

Tower Hamlets Cancer Survivorship Rehabilitation Project was initiated as a response to the problem of unmet rehabilitation needs, which include but are not limited to:

- Nutritional advice
- Breathlessness management
- Fatigue management
- Relaxation skills
- Vocational rehabilitation
- Disability counselling
- Carer support and training
- Physical re-conditioning
- Cognitive rehabilitation

Cancer type	Estimated number of survivors		
Breast	870		
Lung	245		
Colorectal (bowel)	425		
Prostate	315		
Other cancers	1660		
Total	3515		

Table 6: Estimated cancer survivors in Tower Hamlets 2009

Supportive and Palliative Care

Around 330 people die from cancer in Tower Hamlets each year. Patients whose cancer is no longer amenable to treatment and who are approaching the end of life should be offered care in accordance with the NICE guidance⁽²³⁾ on supportive and palliative care and the National End of Life Care Strategy ⁽²⁴⁾. There is a section in this report on Tower Hamlets approach to delivering high quality services for end of life care in Chapter One. The Tower Hamlets Palliative Care Centre provides a single point of access and co-ordination of services for patients and families, as well as health, social and voluntary care staff.

Recommendations

Prevention

- Continue to provide targeted interventions to support people
 - to stop smoking and tobacco usage
 - to eat more healthily by increasing fruit and vegetables and reducing salt, sugar, saturated fat and red meat
 - to increase physical activity
 - to maintain a healthy weight
 - to maintain safe levels of alcohol consumption
- Continue to achieve at least 94% uptake of Human Papilloma Virus immunisation for girls aged 13 and 14 years
- Use recommendations of local social marketing research specifically targeting younger women to achieve cervical screening coverage of 80% by 2014.

Detecting cancer earlier

- Use the findings of research into local people's knowledge about cancer symptoms and risks to provide interventions aimed at improving awareness of cancer signs and of lifestyle risk factors. These should:
 - target women and people in more deprived areas
 - use communication campaigns and primary care initiatives which empower people to increase awareness of symptoms and to believe that their symptoms are important

- raise awareness of bowel cancer and bowel cancer screening
- Use the findings of the audit of cancer referrals by GPs to help identify and reduce delays in referral and diagnosis. Work with GPs to:
 - use this as a baseline against which interventions to increase early diagnosis can be evaluated.
 - provide tailored education and updates for GPs about cancer treatments and outcomes, with emphasis on identifying and referring possible cancers urgently for assessment.
- Explore how to improve access to diagnosis in primary care through "one-stop" assessment clinics for common cancers and direct access by GPs to diagnostic services.
- Participate in the pilot of the risk assessment tool for primary care, to aid early recognition of symptoms of lung and bowel cancers.
- Disseminate new cancer referral guidelines to GPs once they are published.
- Increase the uptake of screening for breast cancer to achieve 75% coverage for women aged 53 to 70 years by March 2015. Begin to extend screening to women aged 47 to 73 years by 2011 and offer screening to women at risk of familial breast cancer.
- Evaluate the impact of different interventions which have contributed to improving the uptake and coverage of breast cancer screening to inform future investment
- Increase the uptake of cervical screening to achieve the national standard of 80% coverage for women aged 25– 64 years by March 2014. Develop a Network Improved Service (NIS) to incentivise primary care to achieve the national standard
- Test and evaluate the impact and effectiveness of different approaches to increasing the uptake and coverage of

bowel cancer screening, particularly amongst people in lower socio-economic and different ethnic groups.

- Extend bowel screening to men and women aged 70 74 years.
- Increase the uptake of bowel cancer screening towards achieving the national standard of 60% over the next 5 years.
- Work with hospital services to continue to improve the quality of cancer data, particularly electronic information on the stage of cancer at diagnosis, to help evaluate the impact of interventions aimed at increasing early diagnosis and improving survival.

Ensuring better treatment

- Undertake research into pathways for local people with cancer, focusing on the commonest cancers, to identify inequalities in incidence, stage of diagnosis, treatment and survival. This will include detailed analysis of data and pathways for different tumour sites to ensure that budgets are allocated effectively, with most impact on outcomes for patients.
- Ensure stronger commissioning to ensure that people with cancer have access to high quality services as defined by the National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG) and that they receive optimal treatment for their condition

Living with Cancer

• Ensure that the needs of cancer survivors are met using evidence based services, responding to the expressed needs of service users and making the most effective use of resources.

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